

Provider Manual

2018-2019



Table of Contents

Section 1. Addresses and Phone Numbers	8
Provider Services Department	8
Member Services Department	8
Claims Department	8
Claims Recovery Department	9
Compliance and Fraud AlertLine.....	9
Credentialing Department	9
Nurse Advice Line.....	10
Healthcare Services (UM) Department	10
Behavioral Health.....	11
Pharmacy Department	11
Pharmacy Claims.....	12
Quality Department.....	12
Dental Services.....	12
Molina Healthcare of Puerto Rico, Inc. Service Area	13
Section 2. Enrollment, Eligibility and Disenrollment	14
Enrollment.....	14
Enrollment in Government Health Program (GHP)	14
Effective Date of Enrollment	14
Newborn Enrollment	14
Inpatient at Time of Enrollment	15
Eligibility Verification	15
Medicaid Programs	15
Eligibility Listing for Medicaid Programs.....	15
Identification Cards	15
Disenrollment.....	16
Voluntary Disenrollment.....	16
Involuntary Disenrollment	17
PCP Dismissal	17
Missed Appointments.....	18
PCP and PMG Assignment.....	18
PCP and PMG Changes	19
Section 3. Member Rights and Responsibilities	20
Second Opinions.....	20
Section 4. Benefits and Covered Services	21
GHP Overview/Description	21
The MHPR Preferred Provider Network (PPN) and General Network	21
Member Cost Sharing	22
Government Health Plan Benefits.....	24
Services Not Covered by the GHP (Basic Coverage)	26
Prescription Drugs	27
Non-Formulary Drug Exception Request Process	28
Injectable and Infusion Services	29
Access to Behavioral Health Services	29

Covered Behavioral Health/Mental Health Services	29
Emergency Mental Health or Substance Abuse Services	30
Emergency Transportation.....	30
Non-Emergency Medical Transportation.....	30
Family Planning Services.....	31
Preventive Care	31
Immunizations.....	32
Well Child Visits and EPSDT Guidelines	32
Prenatal Care.....	33
Emergency Services	33
Nurse Advice Line.....	33
Health Management.....	34
Health Education/Disease Management.....	34
Program Eligibility Criteria and Referral Source.....	34
Provider Participation.....	35
Section 5. Provider Responsibilities.....	36
Nondiscrimination of Healthcare Service Delivery	36
Section 1557 Investigations	36
Role of Primary Care Provider (PCP)	36
Facilities, Equipment and Personnel.....	37
Provider Data Accuracy and Validation.....	37
Molina Healthcare Electronic Solutions Requirements	38
Balance Billing	40
Member Information and Marketing	40
Member Rights and Responsibilities.....	41
Member Eligibility Verification	41
Healthcare Services (Utilization Management and Case Management)	41
In Office Laboratory Tests.....	41
Referrals	42
Admissions	42
Participation in Utilization Review and Care Management Programs	42
Continuity and Coordination of Provider Communication.....	42
Treatment Alternatives and Communication with Members.....	43
Pregnancy Notification Process	43
Prescriptions	43
Pain Safety Initiative (PSI) Resources	43
Participation in Quality Programs.....	43
Access to Care Standards	44
Site and Medical Record-Keeping Practice Reviews	44
Delivery of Patient Care Information	44
Compliance	44
Confidentiality of Member Health Information and HIPAA Transactions	45
Participation in Grievance and Appeals Programs.....	45
Participation in Credentialing	45
Delegation.....	46
Section 6. Healthcare Services	47

Introduction	47
Utilization Management	47
Medical Necessity Review	48
Clinical Information	48
Prior Authorization	49
Requesting Prior Authorization	50
Affirmative Statement about Incentives.....	50
Open Communication about Treatment	51
Utilization Management Functions Performed Exclusively by Molina	51
Delegated Utilization Management Functions.....	52
Communication and Availability to Members and Providers	52
Levels of Administrative and Clinical Review	52
Hospitals	53
Admissions	54
Inpatient Management	54
Elective Inpatient Admissions	54
Emergent Inpatient Admissions	54
Prospective/Pre-Service Review.....	54
Inpatient Review	55
Inpatient Status Determinations.....	55
Discharge Planning.....	55
Post Service Review	56
Readmission Policy.....	56
Definitions	57
Non-Network Providers.....	57
Out of Network Services	57
Avoiding Conflict of Interest	58
Coordination of Care and Services	58
Continuity of Care and Transition of Members.....	58
Organization Decisions	59
Reporting of Suspected Abuse of an Adult	60
Emergency Services	61
Continuity and Coordination of Provider Communication.....	62
Care Management	62
PCP Responsibilities in Care Management Referrals.....	62
Care Manager Responsibilities	62
Health Management.....	63
Health Education/Disease Management.....	63
Member Newsletters	63
Member Health Education Materials	63
Program Eligibility Criteria and Referral Source.....	64
Provider Participation.....	64
Case Management (CM).....	64
Medical Record Standards.....	65
Medical Necessity Standards.....	66
Section 7. Quality	68

Quality Department	68
Patient Safety Program	68
Quality of Care	69
Medical Records	69
Medical Record Keeping Practices	69
Content	70
Organization	71
Retrieval.....	71
Confidentiality	71
Access to Care.....	72
Appointment Access	72
Office Wait Time	74
After Hours.....	74
Appointment Scheduling	74
Women’s Health Access	75
Monitoring Access Standards	75
Quality of Provider Office Sites	76
Physical Accessibility	76
Physical Appearance	76
Adequacy of Waiting and Examining Room Space.....	76
Adequacy of Medical Record-Keeping Practices	76
Monitoring Office Site Review Guidelines and Compliance Standards	77
Administration & Confidentiality of Facilities	77
Improvement Plans/Corrective Action Plans.....	78
Advance Directives (Patient Self-Determination Act).....	78
EPSDT Services to Enrollees Under Twenty-One (21) Years	80
Well Child/Adolescent Visits	80
Monitoring for Compliance with Standards	81
Quality Improvement Activities and Programs	81
Health Management.....	81
Care Management	81
Clinical Practice Guidelines	82
Preventive Health Guidelines.....	83
Cultural and Linguistic Services	83
Measurement of Clinical and Service Quality	83
HEDIS®	84
Consumer Assessment of Healthcare Providers and Systems (CAHPS®).....	84
ECHO® Survey.....	84
Provider Satisfaction Survey	85
Effectiveness of Quality Improvement Initiatives.....	85
Section 8. Claims and Compensation.....	86
Hospital-Acquired Conditions and Present on Admission Program	86
Claim Submission	87
Required Elements	88
National Provider Identifier (NPI)	88
Electronic Claims Submission.....	88

EDI Claims Submission Issues	90
Paper Claim Submissions	90
Coordination of Benefits and Third Party Liability	90
COB	90
Third Party Liability	90
Timely Claim Filing.....	90
Reimbursement Guidance and Payment Guidelines	91
Coding Sources	92
Definitions	92
Claim Auditing.....	92
Corrected Claims	92
Timely Claim Processing	93
Electronic Claim Payment.....	93
Overpayments and Incorrect Payments Refund Requests	94
Provider Claim Disputes/Reconsiderations.....	94
Appeals Filing Timeframes	95
Billing the Member	95
Fraud and Abuse	96
Encounter Data.....	96
Section 9. Compliance	97
Fraud, Waste, and Abuse	97
Regulatory Requirements	98
Examples of Fraud, Waste and Abuse by a Provider.....	100
Examples of Fraud, Waste, and Abuse by a Member.....	101
Review of Provider Claims and Claims System	101
Prepayment Fraud, Waste, and Abuse Detection Activities.....	102
Post-payment Recovery Activities.....	102
Review of Provider.....	103
Provider Education.....	103
Reporting Fraud, Waste and Abuse.....	103
HIPAA Requirements and Information	104
Molina Healthcare’s Commitment to Patient Privacy	104
Provider Responsibilities.....	105
Applicable Laws	105
Uses and Disclosures of PHI	105
Title 42 Part 2, Confidentiality of Substance Use Disorder Patient Records	106
Inadvertent Disclosures of PHI	106
Written Authorizations.....	107
Patient Rights	107
HIPAA Security	108
HIPAA Transactions and Code Sets.....	108
National Provider Identifier.....	109
Additional Requirements for Delegated Providers	109
Reimbursement for Copies of PHI	110
Section 10. Credentialing and Recredentialing	113
Definitions	113

Criteria for Participation in the Molina Network	114
Section 11. Complaints, Grievance and Appeals Process.....	136
Definitions	136
Member Grievance Process	138
Grievance Timelines	138
Member Appeals Process.....	139
Standard Appeals Process and Timeline	139
Expedited Appeals Process and Timeline.....	139
Review by Administrative Law Judge.....	140
Provider Claims Dispute (Adjustment Request)	140
Reporting	141
Record Retention	142
Section 12. Delegation	143
Delegation Criteria	143
Delegation Reporting Requirements.....	149
Section 13. Cultural Competency and Linguistic Services.....	150
Background.....	150
Nondiscrimination of Healthcare Service Delivery	150
Molina Healthcare Institute for Cultural Competency	151
Provider and Community Training.....	151
Integrated Quality Improvement – Ensuring Access	151
Program and Policy Review Guidelines	152
Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services	152
24 Hour Access to Interpreter Services	153
Documentation.....	153
Members with Hearing Impairment	153
Nurse Advice Line.....	154
Section 14. Glossary of Terms.....	155

Section 1. Addresses and Phone Numbers

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider denied Claims review, contracting, and training. The department has Provider Services Representatives who serve all of Molina Healthcare of Puerto Rico's (Molina Healthcare) Provider network. Eligibility verifications can be conducted at your convenience via Molina's Provider Web Portal (Provider Portal).

Provider Services	
Address:	Molina Healthcare of Puerto Rico, Inc. Attn: Provider Services 654 Plaza, Suite 1600 654 Avenida Muñoz Rivera San Juan, PR 00918
Phone:	(888) 558-5501 (Spanish)
Fax:	(787) 200-3251

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and member complaints. Member Services Representatives are available 7:00 am to 7:00 p.m., Monday through Friday, excluding Commonwealth holidays.

Member Services	
Address:	Molina Healthcare of Puerto Rico, Inc. Attn: Member Services 654 Plaza, Suite 1600 654 Avenida Muñoz Rivera San Juan, PR 00918
Phone:	(877) 335-3305 (Spanish)
TTY/TDD:	711

Claims Department

The Claims Department is located at our main office in Puerto Rico. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims directed to Molina must use Payor ID number 81794. To verify the status of your claims, please call our Provider Claims Representatives at the numbers listed below:

Claims	
Address:	Molina Healthcare of Puerto Rico, Inc. PO Box 364828 San Juan, PR 00936-4828
Phone:	(888) 558-5501

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

- Access the Provider Portal (<https://provider.MolinaHealthcare.com>)
- EDI Payer ID 81794.

To verify the status of your claims, please use Molina Healthcare's Provider Portal. For other claims questions contact Provider Services at (888) 558-5501.

Claims Recovery Department

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

Claims Recovery	
Address:	Molina Healthcare of Puerto Rico, Inc. Attn: Claims Recovery PO BOX 364988 San Juan, PR 00918
Phone:	(844) 606-7180

Compliance and Fraud AlertLine

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

Molina Healthcare AlertLine	
Phone:	(866) 606-3889
Website:	https://MolinaHealthcare.alertline.com

Credentialing Department

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

Credentialing	
Address:	Molina Healthcare of Puerto Rico, Inc. Credentialing Department PO Box 364988 San Juan, PR 00936-4988
Phone:	(888) 558-5501
Email:	mhprcredentialing@molinahealthcare.com

Nurse Advice Line

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

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year.	
Phone:	(888) 620-1515 (Spanish)
TTY/TDD:	711

Healthcare Services (UM) Department

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

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

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

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

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

Healthcare Services Authorizations & Inpatient Census	
Provider Portal:	https://provider.MolinaHealthcare.com
Address:	Molina Healthcare of Puerto Rico, Inc. Attn: Healthcare Services 654 Plaza, Suite 1600 654 Avenida Muñoz Rivera San Juan, PR 00918
Phone:	(888) 558-5501
Fax:	(855) 378-3641

Health Management (Health Education/Disease Management)

Molina Healthcare’s Health Management includes Health Education such as weight management, maternity program, smoking cessation, and Disease Management materials, interventions and programs. These services can be incorporated into the Member’s treatment plan to address the Member’s health care needs.

Weight Management and Smoking Cessations Programs	
Phone:	(877) 335-2567
Fax:	(855) 378-3641

Health Management/Disease Management and Maternity Programs	
Phone:	(787) 999-6341
Fax:	(855) 378-3641

Behavioral Health

Molina Healthcare maintains a Crisis line, available twenty-four (24) hours per day, seven (7) days per week. Providers and Members can also obtain information about accessing Behavioral Health services by contacting us at the number and address below.

Behavioral Health	
Phone:	(888) 558-5501
Crisis Line:	(787) 622-9803 24 hours per day, 365 days per year

Pharmacy Department

Prescription drugs are covered by Molina Healthcare. The drug formulary and a list of in-network pharmacies are available on the www.MolinaHealthcare.com website, or by contacting Molina Healthcare at the number and address below.

Pharmacy Services	
Address:	Molina Healthcare of Puerto Rico, Inc. Attn: Pharmacy PA 654 Plaza, Suite 1600 654 Avenida Muñoz Rivera San Juan, PR 00918
Phone:	(888) 558-5501
Fax:	(844) 606-7171

Pharmacy Claims

MC-21 Corporation will serve as the Pharmacy Benefit Manager. The Pharmacy Network and claims processing are managed by MC-21. Pharmacies with questions related to network status and claims processing issues are urged to reach out to MC-21 directly.

Pharmacy Claims (MC-21)	
Phone:	(888) 311-6001

Quality Department

Molina Healthcare maintains a Quality Department to work with Members and Providers in administering Molina Healthcare’s Quality Programs.

Quality Department	
Phone:	(787) 200-3300

Dental Services

Dental services covered under the Government Health Program are offered through Delta Dental, Molina’s dental vendor.

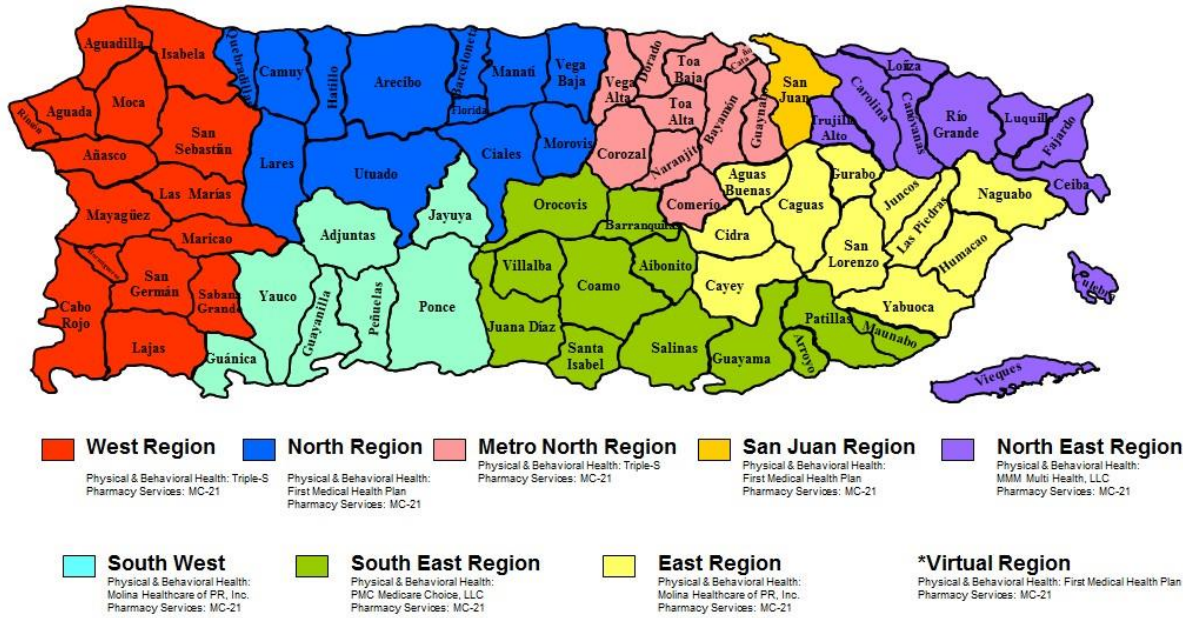
Dental Services	
Phone:	(888) 558-5501

Molina Healthcare of Puerto Rico, Inc. Service Area

The Molina Healthcare service area includes the Island Wide regions.



Puerto Rico Health Insurance Administration Geographic Regions 2014



* **Virtual Region:** The Service Region for the MiSalud Program that is comprised of children who are in the custody of ADFAN, as well as certain survivors of domestic violence referred by the Office of the Women's Advocate, who enroll in the MiSalud Program. The Virtual Region encompasses services for these Enrollees throughout Puerto Rico.

Section 2. Enrollment, Eligibility and Disenrollment

Enrollment

Enrollment in Government Health Program (GHP)

The Government Health Program (GHP) is the program which implements Title XIX of the Social Security Act (Medicaid). It is administered by the Puerto Rico Health Insurance Administration known in Spanish as the Administracion de Seguros de Salud de Puerto Rico (ASES). The Medicaid Program or its agent takes applications and determines the eligibility of individuals and families for GHP.

Only GHP recipients who are included in the eligible populations and living in counties with authorized Health Plans are eligible to enroll and receive services from Molina Healthcare. Molina Healthcare of Puerto Rico, Inc. participates in GHP.

To enroll with Molina Healthcare, the member, his/her representative, or his/her responsible parent or guardian must complete and submit an application to the Medicaid Program.

The member and his/her family will be assigned to the Government Health Plan that services the area where the member resides.

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

Effective Date of Eligibility for Medicaid and CHIP Eligibles is the eligibility period specified on the Form MA-10 which is the first day of the month in which the Potential Enrollee submits its eligibility application with the Medicaid Program Office and they shall be eligible to be enrolled as of that date. For Medicaid and CHIP eligible members, the eligibility period specified on the MA-10 may be a retroactive eligibility period which is up to ninety (90) Calendar Days.

Newborn Enrollment

Molina Healthcare contacts expectant members sixty (60) days after the delivery date to encourage the mother to choose a PCP for her newborn. When a Molina Healthcare member gives birth, the newborn need to be enroll in Medicaid prior to be enrolled with Molina. The Mother will be notified of the auto-assignment and will have ninety (90) days from the date of assignment to change plans. Coverage will be retroactive to the time of birth.

PCP's are required to notify Molina Healthcare via the Pregnancy Notification Report (included in Appendix B of this manual) immediately after the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services.

Effective Date of Enrollment for Newborns

The Effective Date of Enrollment for Medicaid and CHIP Eligible newborns is the date of his or her birth. The Effective Date of Enrollment for Commonwealth Population newborns is the date the newborn is registered with the Puerto Rico Medicaid Program.

Inpatient at Time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge, the program or plan the Member 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 Member is no longer confined to an acute care hospital.

Eligibility Verification

Medicaid Programs

The Commonwealth of Puerto Rico, through ASES determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and Molina Healthcare places the responsibility for eligibility verification on the provider of services. Molina Healthcare will not reimburse providers for services if the member was not eligible with Molina Healthcare on the date the service(s) were rendered.

Eligibility Listing for Medicaid Programs

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

- Molina Healthcare Provider Services at (888) 558-5501.
- Molina Web Portal <https://provider.MolinaHealthcare.com>

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

Identification Cards

Molina Healthcare of Puerto Rico, Inc. Sample Member ID card.

MOLINA HEALTHCARE
OF PUERTO RICO, INC.

Vital
Salud en tus manos
GOBIERNO DE PUERTO RICO

JUAN DEL PUEBLO

MPI :0080000012345
 Fecha de efectividad : 11/01/18
 Cubierta : F-110
 PCP : DR. DEL PUEBLO
 PMG # : 90775
 PMG : GRUPO MEDICO ABC

Beneficios Farmacia
 BIN/PCN : 010868/HCR
 Grupo Rx : GHMOL
 RxPref : \$ 0
 RxNonPref : \$ 0
 Copagos no aplican a menores de 21 años y mujeres embarazadas.
 Copagos dentro de la red preferida son \$0

Copagos Fuera PPN
 Generalista : \$ 0
 Especialista : \$ 0
 Subespecialista : \$ 0
 Hospital : \$ 0
 ER: \$ 0
 No ER Hosp/No ER No Hosp: \$ 0 / \$ 0
 Lab/X-Ray : \$ 0 / \$ 0
 Dental Prev: \$ 0 Rest: \$ 0

ASES
ADMINISTRACIÓN DE SERVICIOS DE SALUD DE PUERTO RICO

Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider’s responsibility to ensure Molina Healthcare Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to request to change plans for any reason within the first ninety (90) days of enrollment and at the end of each twelve (12) month enrollment period thereafter. Members may request to change plans for cause at any time. Circumstances that constitute cause for disenrollment include the member moving out of the Service Area, Molina Healthcare does not provide covered services Member

seeks based on moral or religious objections, member needs services that are not available within the Molina Healthcare network, member's eligibility changes, or other reasons per 42 CFR 438.56(d)(2). Members can change plans by calling Molina Healthcare Member Services at (877) 335-3305. Molina Healthcare will provide assistance to members requesting to disenroll from the Molina Healthcare plan, and will refer the member to ASES or its agent for disenrollment determination.

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

Involuntary Disenrollment

Under very limited conditions and in accordance with ASES guidelines, members may be involuntarily disenrolled from a managed care program. With proper written documentation and approval by ASES or its Agent; the following are acceptable reasons for which Molina Healthcare may submit Involuntary Disenrollment requests to ASES:

- Member has moved out of the Service Area.
- Member death or incarceration.
- Member's continued enrollment seriously impairs the ability to furnish services to this member or other members.
- Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness.
- Member's utilization of services is fraudulent or abusive.
- Member is placed in a long-term care nursing facility, or intermediate care facility for the developmentally disabled.
- Member's Medicaid eligibility category changes, or member otherwise becomes ineligible to participate in GHP.

PCP Dismissal

A PCP may request the dismissal of a member from his/her practice based on member behavior. Reasons for dismissal must be documented by the PCP and may include:

- A member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.
- A member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her assignment to the provider seriously impairs the provider's ability to furnish services to either the member or other members.

This Section does not apply if the Member's behavior is attributable to a physical or behavioral condition.

Missed Appointments

Participating Providers are responsible for establishing a process for documenting missed appointments. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider should notify Molina Healthcare Provider Services at (888) 558-5501.

PCP and PMG Assignment

Molina Healthcare will offer each member a choice of PMGs and PCPs. Molina Healthcare will make the following recommendations to members in choosing a PCP:

- Female members will be recommended to choose an OB/GYN as a PCP
- Members under twenty-one (21) years of age will be recommended to choose a pediatrician as a PCP
- Members with Chronic Conditions including heart failure, kidney failure, or diabetes will be recommended to choose an internist as a PCP.

After making a choice, each member will have a single PCP and a single PMG. Molina Healthcare will assign a PCP and a PMG to those members who did not choose a PCP and PMG at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the member's home address, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN). Molina Healthcare will assign all members that are reinstated after a temporary loss of eligibility of sixty (60) days or less to the PCP and PMG assigned prior to loss of eligibility, unless the member specifically requests another PCP, the PCP no longer participates in Molina Healthcare or is at capacity, or the member has changed geographic areas.

Members must choose a PCP for each insured member in the family. The PCP may be different for each individual in the family, but they must belong to the same PMG.

Molina Healthcare will allow pregnant members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Molina Healthcare shall assign a pediatrician or other appropriate PCP to all pregnant members for the care of their newborn babies no later than the beginning of the last trimester of gestation. If Molina Healthcare was not aware that the member was pregnant until she presented for delivery, it will assign a pediatrician or a PCP to the newborn baby within one (1) business day after notification of birth. Providers shall advise all members of the members' responsibility to notify Molina Healthcare and ASES of their pregnancies and the births of their babies.

PCP and PMG Changes

Members may change their PMG and/or PCP for any reason during the first ninety (90) calendar days from the enrollment date. Members may also change their PCP and/or PMG for any reason once every twelve (12) months following the ninety (90) days after the effective date of enrollment.

Members may change their PCP or PMG at any time if there is Good Cause. The following are considered Good Cause for a change:

1. Member moves out of the region.
2. For moral or religious reasons, the provider does not render the services the member needs.
3. The member needs services that must be rendered at the same time as other services and not all services are available. Not receiving all of the services as ordered may put the member at unnecessary risk.
4. Other reasons may include, but are not limited to:
 - Poor quality of services.
 - Lack of access to covered services.
 - Lack of providers with experience to address the member's health care needs.

Section 3. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Healthcare Member Handbook and on the Molina Healthcare website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link: www.psgMolinaHealthcare.com

Member Rights and Responsibilities are outlined under the heading “your Rights and Responsibilities” within the Member Handbook document.

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

For additional information, please contact Molina Healthcare at (888) 558-5501, Monday to Friday from 7:00 am to 7:00 pm, excluding Puerto Rico holydays. TTY users, please call 711.

Second Opinions

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

Section 4. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina Healthcare Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization please contact Molina at (888) 558-5501, Monday to Friday from 7:00 am to 7:00 pm, excluding Puerto Rico holidays, or by accessing benefit details available on our Provider Portal at: <https://provider.MolinaHealthcare.com>.

GHP Overview/Description

The Government Health Plan (“GHP Vital”) is the government health services program offered by the Commonwealth of Puerto Rico, and administered by ASES, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health Services. The GHP offers the broadest benefit coverage through a coordinated care model.

Under this model there is a Preferred Provider Network within each Primary Medical Group (PMG). Members select a PMG and a PCP (from within the PMG) and can freely visit any provider within the Preferred Provider Network without the need for referrals or paying Copayments.

Under the Government Health Plan, members do not need the Primary Care Physician’s approval, or countersignature, on the prescriptions ordered by providers within the selected PMG’s Preferred Provider Network. Members can freely choose dentists and pharmacies, as long as they are in Molina Healthcare’s network.

In addition, members can receive mental health services within the same facility of the PMG. The Government Health Plan requires integrated physical and mental health services, so members can receive these services in one place.

Please contact Molina if you would like additional information.

The MHPR Preferred Provider Network (PPN) and General Network

Molina Healthcare of Puerto Rico (MHPR) is committed to improving access to specialty care for our Members.

- Primary care and preventive services are available from contracted primary care providers participating with MHPR in Primary Medical Groups (or “PMGs”).
- Along with the PMGs, MHPR’s Preferred provider Network (or “PPN”) is our contracted provider network of specialists and other providers available on an “open access” basis for Members assigned to all of our contracted PMGs in the East and Southwest regions.
 - Example – Should MHPR have four hospitals and 500 specialists and ancillary providers in the PPN, all of those PPN providers will be listed and available to Members assigned to PMG #1, PMG#2, PMG#3 etc.

- The MHPR General Network will be composed of hospitals, ancillary and other providers that are (i) not part of the PMGs and PPN, and/or (ii) located outside of the East and Southwest service regions.
- Member Access and PCP processes are streamlined as follows:
 - No referrals will be needed to see a PPN provider; Referrals are required outside of the PPN.
 - As a Managed Care Organization we encourage a written consultation be provided first to the specialist by the PCP and subsequently by the specialist to the PCP in order to maintain proper and effective communication for the benefit of the member's care.
 - No copays will apply to the PPN and General Network for Medicaid and CHIP members (Commonwealth membership will continue to pay applicable co-pays when going outside of the PPN).
 - Prescriptions will not require a co-signature of the PCP if written by a contracted provider within the PPN.
- MHPR's provider directory will list the contracted PMGs along with our PPN and General Network providers.
- The usual processes for referrals, co-pays and required co-signatures for prescriptions will apply for Members obtaining services from providers in the General Network or out-of-network providers.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that members must pay for Covered Services provided under the Government Health Plan. It is the provider's responsibility to collect the copayment and other member Cost Share from the member. The amount of the copayment and other Cost Sharing will be deducted from the Molina payment for all claims involving Cost Sharing. Providers may not charge members fees for covered services beyond copayments or coinsurance.

There may be co-payments or co-insurance for some services, depending upon the type of membership and whether services are accessed within the PPN or within the general network. The table below gives an overview of co-payments and co-insurance rates which may be changed by ASES. The Cost Sharing amount that members will be required to pay for each type of Covered Service may be summarized on the member's ID card. Additional detail regarding cost sharing available on the Provider Web Portal (<https://provider.MolinaHealthcare.com>) or by contacting Molina Healthcare at (888) 558-5501.

CO-PAYS & CO-INSURANCE - effective on July 1st 2016											
SERVICES	Federal				CHIPs		Commonwealth				*ELA
	100	110	120	130	220	230	300	310	320	330	400
HOSPITAL											
Admissions	\$0	\$4	\$5	\$8	\$0	\$0	\$15	\$15	\$15	\$20	\$50
Nursery	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
EMERGENCY ROOM (ER)											

CO-PAYS & CO-INSURANCE - effective on July 1st 2016											
SERVICES	Federal				CHIPs		Commonwealth				*ELA
	100	110	120	130	220	230	300	310	320	330	400
Emergency Room (ER) Visit	\$0	\$0	\$0	\$0	\$0	\$0	\$2	\$10	\$15	\$20	\$20
Non-Emergency Services Provided in a Hospital Emergency Room, (per visit)	\$0	\$4	\$5	\$8	\$0	\$0	\$20	\$20	\$25	\$30	\$20
Non-Emergency Services Provided in a Freestanding Emergency Room, (per visit)	\$0	\$2	\$3	\$4	\$0	\$0	\$20	\$20	\$25	\$30	\$20
Trauma	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
AMBULATORY VISITS TO											
Primary Care Physician (PCP)	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$5	\$3
Specialist	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$5	\$7
Sub-Specialist	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$5	\$10
Pre-natal services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
OTHER SERVICES											
High-Tech Laboratories**	\$0	50¢	\$1	\$1.50	\$0	\$0	\$2	\$2	\$5	\$5	20%
Clinical Laboratories**	\$0	50¢	\$1	\$1.50	\$0	\$0	\$2	\$2	\$5	\$5	20%
X-Rays**	\$0	50¢	\$1	\$1.50	\$0	\$0	\$2	\$2	\$5	\$5	20%
Special Diagnostic Tests**	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$6	40%
Therapy – Physical	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$5	\$5
Therapy – Respiratory	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$5	\$5
Therapy – Occupational	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$5	\$5
Vaccines	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Healthy Child Care	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DENTAL											
Preventive (Child)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Preventive (Adult)	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$3	\$5	\$3
Restorative	\$0	\$1	\$1.50	\$2	\$0	\$0	\$2	\$2	\$5	\$6	\$10
PHARMACY***											
Preferred (Children 0-21)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$5
Preferred (Adult)****	\$0	\$1	\$2	\$3	N/A	N/A	\$3	\$3	\$5	\$5	\$5
Non-Preferred (Children 0-21)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$10
Non-Preferred (Adult)****	\$0	\$3	\$4	\$6	N/A	N/A	\$8	\$8	\$10	\$10	\$10

APPROVED: JUNE 16, 2016

*Code 400 in ELA column refers to the population that subscribes as public employees of the Puerto Rico Government.

**Apply to diagnostic tests only. Copays do not applied to tests required as part of a preventive service.

***Copays apply to each drug included in the same prescription pad. Pharmacy exception (children zero to eighteen [0-18]) does not apply to 400 ELA employees.

****Co-pays for children zero to eighteen (0-18) years of age are not applicable for Medicaid, Commonwealth medically indigent eligible, and for children zero to eighteen (0-18) enrolled in the CHIP Program in group ages zero to eighteen (0-18).

Co-pays may apply to children ages over eighteen (18) years old as well as to adults.

Some benefits may have limitations. Please call the Provider Services Department for addition information or for a complete list of benefits at (888) 558-5501.

Government Health Plan Benefits

Service Covered by Molina

- Preventive Services
- Diagnostic Test Services
- Outpatient Rehabilitation Services
- Medical and Surgical Services
- Emergency Transportation Services
- Maternity and Pre-Natal Services
- Emergency Services
- Post Stabilization Services
- Hospitalization Services
- Behavioral Health Services
- Pharmacy Services
- Dental Services

New or Enhanced Benefits

- Members now have access to benefits for Smoking Cessation (counseling and medication).

Services covered under Special Coverage by Molina (Applicable to Enrollees who are entitled to Medically Necessary treatment for Special Coverage qualifying condition)

- Coronary and intensive care services, without limit;
- Maxillary surgery;
- Neurosurgical and cardiovascular procedures, including pacemakers, valves, and any other instrument or artificial devices (Prior Authorization required);
- Peritoneal dialysis, hemodialysis, and related services (Prior Authorization required);
- Pathological and clinical laboratory tests that are required to be sent outside Puerto Rico for processing (Prior Authorization required);
- Neonatal intensive care unit services, without limit;
- Radioisotope, chemotherapy, radiotherapy, and cobalt treatments;

- Treatment of gastrointestinal conditions, treatment of allergies, and nutritional services in autism patients;
- The following procedures and diagnostic tests, when Medically Necessary (Prior Authorization required):
- Computerized Tomography;
- Magnetic resonance test;
- Cardiac catheters;
- Holter test;
- Doppler test;
- Stress tests;
- Lithotripsy;
- Electromyography;
- Single-photon Emission Computed Topography (“SPECT”) test;
- Orthopantomogram (“OPG”) test;
- Impedance Plethymography;
- Other neurological, cerebrovascular, and cardiovascular procedures, invasive and noninvasive;
- Nuclear imaging;
- Diagnostic endoscopies; and
- Genetic studies;
- Up to fifteen (15) additional (beyond the services provided under Basic Coverage) physical therapy treatments per Enrollee condition per year when indicated by an orthopedist, physiatrist or chiropractor after Contractor Prior Authorization;
- General anesthesia, including for dental treatment of special-needs children;
- Hyperbaric Chamber;
- Immunosuppressive medicine and clinical laboratories required for the maintenance treatment of post-surgical patients or transplant patients, to ensure the stability of the Enrollee's health, and for emergencies that may occur after said surgery; and
- Treatment for the following conditions after confirmed laboratory results and established diagnosis:
- HIV Positive factor and/or Acquired Immunodeficiency Syndrome (“AIDS”) (Outpatient and hospitalization services are included; no Referral or Prior Authorization is required for Enrollee visits and treatment at the Health Department's Regional Immunology Clinics or other qualified Providers);
- Tuberculosis;
- Leprosy;
- Lupus;
- Cystic Fibrosis;
- Cancer;
- Hemophilia;
- Special conditions of children, including the prescribed conditions in the Special Needs Children Diagnostic Manual Codes, except: Asthma and diabetes, which are included in the Disease Management program; Psychiatric Disorders; and Intellectual disabilities;
- Scleroderma;

- Multiple Sclerosis;
- Conditions resulting from self-inflicted damage or as a result of a felony or negligence by an Enrollee; and,
- Chronic renal disease in levels three (3), four (4) and five (5). (Levels 1 and 2 are included in the Basic Coverage)

Services Not Covered by the GHP (Basic Coverage)

The following services are excluded from Basic Coverage; if you have any questions about the list or regarding your coverage please call Molina.

- Services to Patients not eligible to the Government Health Plan.
- Services for non-covered illnesses or trauma.
- Services for automobile accidents covered by the Administration of Compensation for Automobile Accidents (ACAA, for its acronym in Spanish).
- Accidents on the job that are covered by the State Insurance Fund Corporation.
- Services covered by another insurance or entity with primary responsibility (third party liability).
- Specialized nursing services for the comfort of the Patient when they are not medically necessary.
- Hospitalizations for services that can be rendered on an outpatient basis.
- Hospitalization of a Patient for diagnostic services only.
- Expenses for services or materials for the Patient's comfort such as telephone, television, admission kits, etc.
- Services rendered by Patient's relative (parents, children, siblings, grandparents, grandchildren, spouse, etc.).
- Organ and tissue transplants, except skin, bone and corneal transplants.
- Weight control Treatments (obesity or weight increase for aesthetic reasons).
- Sports medicine, music therapy and natural medicine.
- Cosmetic surgery to correct physical appearance defects.
- Services, diagnostic tests ordered or provided by naturopaths, naturists, and iridologists.
- Health Certificates except for (i) venereal disease research laboratory tests, (ii) tuberculosis tests and (iii) any certification related to the eligibility for the Medicaid program. Mammoplasty or plastic reconstruction of breast for aesthetic purposes only.
- Outpatient use of fetal monitor.
- Services, Treatment or hospitalization as a result of induced, non-therapeutic abortions or their complications. Call Molina Healthcare Member Services to learn more on induced abortions.
- Rebetrone or any other prescribed medication for Hepatitis C Treatment, both Treatment and medications are excluded from the Health Plan coverage. The medications as well as the Treatment will be provided by the Hepatitis Program of the Health Department. For additional information refer to the Hepatitis Section previously mentioned in this Handbook.

- Medications delivered by a provider that does not have a pharmacy license, with the exception of medications that are traditionally administered in a doctor's office such as an injection.
- Epidural anesthesia services.
- Services that are not reasonable or necessary according to the regulations accepted in the practice of medicine. Services rendered in excess to those normally required for diagnostics, prevention, diseases, Treatment, injury or organ system dysfunction or pregnancy condition.
- Mental health services that are not reasonable or necessary according to the accepted regulations for the practice of medical Psychiatry or the services rendered in excess to those usually required for the diagnostic, prevention and Treatment of a mental illness.
- Educational tests, educational services.
- Peritoneal dialysis or hemodialysis services (Covered under the Special Coverage).
- Hospice care for adults
- New or experimental procedures not approved by ASES to be included in the Basic Coverage.
- Custody, rest and convalescence once the disease is under control or in irreversible terminal cases (hospice care for Members under twenty-one [21] is part of basic coverage).
- Services covered under the Special Coverage.
- Services received outside the territorial limit of the Commonwealth of Puerto Rico, except for emergency services for Medicaid or CHIP beneficiaries.
- Judicial order for evaluations for legal purposes.
- Travel expenses, even when ordered by the Primary Care Physician are excluded.
- Eyeglasses, contact lenses and hearing aids (for members over age twenty-one [21]).
- Acupuncture services.
- Procedures for sex changes, including hospitalizations and complications.
- Treatment for infertility and/or related to conception by artificial means including tuboplasty, vasovasectomy, and any other procedure to restore the ability to procreate.
- Expenses incurred for the Treatment of conditions resulting from services not covered under the GHP (maintenance Prescriptions and required clinical laboratories for the continuity of a stable health condition, as well as any emergencies which could alter the effects of the previous procedure, are covered).

Prescription Drugs

Prescription drugs are covered by Molina Healthcare, via the PBM, MC-21 Corporation. Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina Healthcare at (888) 558-5501. For claims issues, MC-21 can be contacted directly at (888) 311-6001.

When prescribing medicines, providers should refer to the ASES Formulary of Medication Covered (FMC) (available at <http://abarcahealth.com/clients/government/ases>) as a first option at the moment of prescribing. In order to prescribe a Formulary medication that is not on the FMC, providers will need to obtain Prior Authorization from Molina before issuing a prescription. Providers may not outright deny prescribing a medication because it is not included on the FMC. Instead, a Prior Authorization should be sought when the non-FMC medication is medically necessary. When listed on the Formulary and FMC, generic drugs should be prescribed instead of their brand name counterparts.

Non-Formulary Drug Exception Request Process

The physician may request a prior authorization for clinically appropriate drugs that are not covered under the Member's Formulary of Medications Covered (FMC). Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina Healthcare's decision within twenty-four (24) hours of receiving the complete request.
- If the initial request is denied, the prescribing physician, pharmacy and patient will be verbally notified by the MCO's representatives within the applicable timeframes required in the preceding sections. A denial letter also will be mailed within three (3) business days of verbal notification.
- Members will also have the right to appeal a denial decision, per any requirements set forth by ASES.
- Molina Healthcare will allow a seventy-two (72)-hour emergency supply of prescribed medication for dispensing at any time that a Prior Authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Special Medications

Certain Medications for the treatment of HIV/AIDS are excluded from the ASES PDL and instead, providers should refer members to CPTET Centers (Centros de Prevencion y Tratamiento de Enfermedades) or community-based organizations, where the member may be screened to determine whether the member is eligible for the AIDS Drug Assistance Program ("ADAP"). Those medications are: Viread®, Emtriva®, Truvada®, Fuzeon®, Atripla®, Epzicom®, Selzentry®, Intelence®, Isentress®, Edurant®, Complera®, and Stribild®.

Any medications for the treatment of Hepatitis C are excluded from coverage. These medications can be provided by the Health Department, upon referral to the Health Department by a Network Provider.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). More information about our Prior Authorization process, is available in the Medical Management Program section of this Provider Manual.

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

Access to Behavioral Health Services

Members in need of Behavioral Health Services can be referred by their PCP for services or Members can self-refer by calling Molina Healthcare at (888) 558-5501. Molina Healthcare is available twenty-four (24) hours a day, seven (7) days a week for behavioral health needs. The services members receive will be confidential.

Covered Behavioral Health/Mental Health Services

Molina covers the following mental health services:

- Evaluation, screening and Treatment to individuals, couples, families and groups.
- Ambulatory services rendered by psychiatrists, psychologists and social workers.
- Hospital and ambulatory services for substance abuse and alcoholism.
- Intensive ambulatory services.
- Emergency and crisis intervention services available twenty-four (24) hours a day, seven (7) days a week.
- Detoxification services for beneficiaries that use illegal drugs, have had suicidal attempts or accidental poisoning.
- Administration of and Treatment with Buprenorphine (requires Preauthorization).
- Clinics for injectable extended-release medications.
- Escort, professional assistance and ambulance services when the services are necessary.
- Prevention services and secondary education.
- Pharmacy coverage and Access to medications within twenty-four (24) hours.
- Laboratory tests that are medically necessary.
- Treatment for Patients diagnosed with Attention Deficit Disorder (ADD) with or without hyperactivity (ADHD). This includes, but is not limited to, visits to neurologists and tests related to the Treatment of this diagnosis.
- Consultations and coordination with other Agencies.
- Substance abuse Treatment.

Mental Hospitalization Services

- Partial hospitalization services for cases referred by a psychiatrist for primary phase diagnosis and Treatment, according to the parity provisions of Law 408 of October 2, 2000.

- Hospitalization that presents a mental pathology that is not drug abuse when referred by a psychiatrist for primary phase diagnosis and Treatment, according to the parity provisions of Law 408 of October 2, 2000.

Emergency Mental Health or Substance Abuse Services

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

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

Out of Area Emergencies

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

- Go to the nearest hospital or facility.
- Call the number on ID card.
- Call Member’s PCP and follow-up within twenty-four (24) to forty-eight (48) hours.

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

Emergency Transportation

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

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

Sea, air and land transportation will be covered within Puerto Rican territory limits in cases of emergency. These services do not require Preauthorization or precertification.

Emergency transportation services are covered in the US for members who are Medicaid or CHIP eligible, if the emergency transportation is associated with an Emergency Service in the US.

Non-Emergency Medical Transportation

Molina Healthcare will be offering limited transportation services if certain conditions apply. This benefit requires prior authorization and will be available on a case-by-case basis to assist our members in accessing care if the ASES-established transportation process or other free transportation resources cannot meet the member's need. These limited services will be provided through, Molina Healthcare's transportation partner. The transportation partner will need seventy-two (72) hours advance notice to schedule trips. To check on the availability of this benefit, and to schedule transportation contact Molina at (888) 558-5501.

In addition to this limited benefit, each Municipality in Puerto Rico has a variety of free transportation services available to assist members in getting to medical appointments. To access the services and ask about free non-emergency medical transportation options members may:

- Contact the local Municipal office.
- Ask the PCP or PMG.
- Call Molina Member Services.

Family Planning Services

Family planning services coverage is provided to ensure that women have the benefits of a healthy and safe sexual and reproductive life by providing access to quality services for family planning and contraception, with full respect for a woman's rights and her free choice. The benefits of family planning and contraception through the promotion of health, are designed to facilitate the exercise of responsible sexuality and protection, within a framework of respect for the rights of people.

Specific services include:

- Counseling
- Pregnancy Testing
- Diagnosis and Treatment of Sexually Transmitted Diseases
- Infertility Assessments
- At least one of every class of FDA approved oral contraceptive medication as specified in ASES's PDL (prescribed by an OB/GYN)
- Other FDA-Approved contraceptive medication or methods when medically necessary and approved through a prior authorization or an exception process and the prescribing provider can demonstrate at least one of the following situations (prescribed by OB/GYN):
 - Contraindication with drugs that are in the PDL that the member is already taking and there are no other methods in the PDL that can be used by the member;
 - History of adverse reaction by the member to the covered contraceptive methods as specified by ASES; or,
 - History of adverse reaction by the member to the contraceptive medications that are on the PDL.

Preventive Care

Preventive Care Guidelines are located on the Molina Website.

We need your help conducting these regular exams in order to meet the targeted Commonwealth and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (888) 558-5501.

Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics and prescribed by the child's PCP.

Immunization schedule recommendations from the American Academy of Pediatrics and/or the CDC are available at the following website:

<https://www.cdc.gov/vaccines/schedules/hcp/index.html>

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

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. The standards and periodicity schedule generally follow the recommendations from the American Academy of Pediatrics (AAP) and Bright Futures, <https://brightfutures.aap.org>

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 Departamento de Salud de P.R Recommended 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.

We need your help conducting these regular exams in order to meet the HEDIS (Health Care Effectiveness Data Information Set) targeted Commonwealth standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call our Health Education line at (888) 558-5501.

Prenatal Care

Stage of Pregnancy	How often to see the doctor
One (1) month – Six (6) months	One (1) visit a month
Seven (7) months – Eight (8) months	Two (2) visits a month
Nine (9) months	One (1) visit a week

Emergency Services

Emergency Services means: As defined in 42 CFR 438.114, any Physical or Behavioral Health Covered Services (as described in Section 7.5.9) furnished by a qualified Provider in an emergency room that are needed to evaluate or stabilize an Emergency Medical Condition or a Psychiatric Emergency that is found to exist using the prudent layperson standard.

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

Nurse Advice Line

Members may call the Nurse 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)	
Phone:	(888) 620-1515 (Spanish and English)
TTY/TDD:	(787) 522-8281

Molina Healthcare 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.

Health Management

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

Health Education/Disease Management

Molina Healthcare 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 Molina Healthcare's Provider Services Department at (888) 558-5501, TTY/TDD at 711. Visit www.MolinaHealthcare.com

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Healthcare 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 Healthcare 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 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 Healthcare HCS Department toll free at (787) 200-3300.

Section 5. Provider Responsibilities

Nondiscrimination of Healthcare Service Delivery

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

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

Section 1557 Investigations

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

Molina Healthcare, Inc.
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

Role of Primary Care Provider (PCP)

The Primary Care Provider is the manager of the patients' total health care needs. PCPs prescribe and provide routine and preventive medical services, and coordinate all care that is given by Molina Healthcare's specialists and participating facilities or any other medical facility where patients might seek care (e.g., Emergency Services). The

coordination provided by PCPs may include direct provision of primary care; referrals for specialty care; and referrals to other programs including Disease Management, educational program, public health agencies, and community resources.

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a Commonwealth 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 Healthcare in writing at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

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

Please visit our Provider Online Directory at providersearch.MolinaHealthcare.com to validate your information. Please notify your Provider Services Representative at (888) 558-5501 if your information needs to be updated or corrected.

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

Molina Healthcare is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Providers are required to provide timely responses to such communications.

Molina Healthcare Electronic Solutions Requirements

Molina Healthcare requires Providers to utilize electronic solutions and tools to the.

Molina Healthcare requires all contracted Providers to participate in and comply with Molina Healthcare's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA) and registration for and use of Molina's Provider Web Portal (Provider Portal).

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

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

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

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Healthcare Providers include:

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

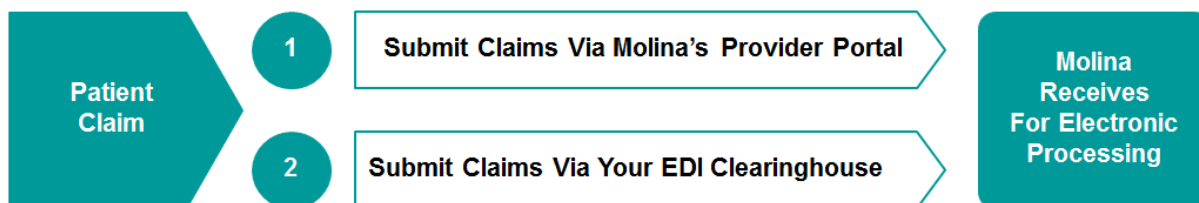
Electronic Claims Submission Requirement

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

- Ensures 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 Healthcare faster.

Molina Healthcare offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare via the Provider Portal. See our Provider Web Portal Quick Reference Guide provider.MolinaHealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina Healthcare through your EDI clearinghouse using Payer ID 81794, refer to our website www.MolinaHealthcare.com for additional information.



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

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

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

Electronic Payment (EFT/ERA) Requirement

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

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina Healthcare’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 Healthcare's Provider Web Portal (Provider Portal). The Provider Portal is an easy to use, online tool available to all of our Providers at **no cost**. The Provider Portal offers the following functionality:

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

Balance Billing

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

Providers may not charge Members fees for covered services beyond copayments, deductibles or coinsurance.

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

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

Member Information and Marketing

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

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 Eligibility Verification

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

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

Healthcare Services (Utilization Management and Case Management)

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

In Office Laboratory Tests

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

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

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

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

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 Healthcare Services 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 Healthcare except in the case of 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.

Admissions

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

Participation in Utilization Review and Care Management Programs

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

Continuity and Coordination of Provider Communication

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

Treatment Alternatives and Communication with Members

Molina Healthcare endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina Healthcare 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.

Pregnancy Notification Process

The PCP shall submit to Molina Healthcare the Pregnancy Notification Report Form (available at www.MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test of any Member presenting themselves for healthcare services. The form should be faxed to Molina at (855) 378-3641.

Prescriptions

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

Pain Safety Initiative (PSI) Resources

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

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

Participation in Quality Programs

Providers are expected to participate in Molina Healthcare'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 section of this Manual.

Access to Care Standards

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

Site and Medical Record-Keeping Practice Reviews

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

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (hard copy or electronic) should contain all information required by Commonwealth and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina Healthcare'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 Commonwealth and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Molina Healthcare for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina Healthcare's Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina Healthcare and/or as required to any governmental agency or any appropriate Commonwealth and Federal authority having jurisdiction.

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

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

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

Participation in Grievance and Appeals Programs

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

Participation in Credentialing

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

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

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

Provider Enrollment as Medicaid Provider

Molina Healthcare of Puerto Rico will ensure that all our Providers Network are Medicaid-enrolled Providers consistent with the Provider disclosure, screening and enrollment requirement of 42 CFR part 455, subparts B and E as incorporated in 42 CFR 438.608(b).

MHPR may execute temporary Provider Contracts pending the outcome of the Medicaid provider enrollment process of up to one hundred twenty (120) Calendar Days but must terminate a Network Provider Immediately upon notification from ASES that the Network Provider cannot be enrolled, or the expiration of one 120 Calendar Day period without enrollment of the Provider, and notify affected Enrollees.

Delegation

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

Section 6. Healthcare Services

Introduction

Molina Healthcare provides care management services to 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 Healthcare 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. You can contact the Molina Healthcare Utilization Management (UM) Department for toll free at (888) 558-5501. The UM Department fax number is (855) 378-3641.

Utilization Management

Molina Healthcare'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 Healthcare'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:

- Managing available benefits effectively and efficiently while ensuring quality care is provided;
- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care;
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring 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;
- Ensuring that UM decision tools are appropriately applied in determining medical necessity decision.
- 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®, Commonwealth and health plan UM standards

Medical Necessity Review

Molina Healthcare only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina Healthcare will use nationally recognized guidelines, which include but are not limited to MCG, McKesson InterQual®, other third party guidelines, CMS guidelines, Commonwealth 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. Inpatient admissions will be notify in 24 hours.

Clinical Information

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

the Molina Healthcare Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Molina Healthcare requires prior authorization for specified services as long as the requirement complies with Federal or Commonwealth regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina Healthcare prior authorization documents are updated annually, or more frequently as appropriate, and the current documents are posted on the Molina Healthcare website at www.MolinaHealthcare.com.

Requests for prior authorizations to the UM Department may be sent by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina Healthcare ID number, etc.)
- 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

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Commonwealth and Federal Law) are excluded from the prior authorization requirements.

Molina Healthcare makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. For expedited request for authorization, we make a determination as promptly as the member's health requires and no later than twenty-four (24) hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provide within seventy-two (72) hours.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (888) 558-5501.

Requesting Prior Authorization

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina Healthcare website, at www.MolinaHealthcare.com.

Web Portal: Participating Providers are required to use the Molina Healthcare Web Portal for prior authorization submissions whenever possible. Instructions for how to submit a Prior Authorization Request are available on the Portal.

Fax: The Prior Authorization form can be faxed to Molina Healthcare at: **(855) 378-3641**. If the request is not on the form provided by Molina, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax 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.** Please include the supporting documentation needed for Molina Healthcare to make a determination along with the request to facilitate your request being made as expeditiously as possible

Phone: Prior Authorizations can be initiated by contacting Molina Healthcare's Healthcare Services Department at **(888) 558-5501**. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:
Molina Healthcare of Puerto Rico
Attn: Healthcare Services Dept.
654 Plaza, Suite 1600
654 Avenida Muñoz Rivera
San Juan, PR 00918

Affirmative Statement about Incentives

Molina Healthcare 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 Healthcare and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Furthermore, Molina Healthcare 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 Healthcare or the delegated group. Molina Healthcare 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 Healthcare 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 Healthcare 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 Healthcare 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.

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina Healthcare (or by an entity acting on behalf of Molina Healthcare) and are never delegated:

1. Transplant Case Management - Molina Healthcare does not delegate management of transplant cases to the medical group. Providers are required to notify Molina Healthcare's UM Department when the need for a transplant evaluation has been identified. Contracted Providers must obtain prior authorization from Molina Healthcare Medicare for transplant evaluations and surgery. Upon notification, Molina Healthcare conducts medical necessity review. Molina Healthcare selects the facility to be accessed for the evaluation and possible transplant.
2. Clinical Trials - Molina Healthcare does not delegate to Providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina Healthcare's contracts.
3. Experimental and Investigational Reviews - Molina Healthcare does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Delegated Utilization Management Functions

Medical Groups/IPAs delegated with UM functions must be prior approved by Molina Healthcare and be in compliance with all current Molina Healthcare policies. Molina Healthcare 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 Healthcare 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 Healthcare HCS staff is accessible (888) 558-5501 during normal business hours, Monday through Friday (except for Holidays), from 7:00 a.m. to 7:00 p.m., for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina Healthcare's Nurse Advice Line is available to Members and Providers twenty-four (24) hours a day, seven (7) days a week at (888) 620-1515. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters. Molina Healthcare's Nurse Advice Line handles urgent and emergent after-hours UM calls.

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

Molina Healthcare'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 Healthcare 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

Determination/Authorization requests that may lead to denial are reviewed by a health professional at Molina Healthcare (medical director, pharmacy director, or appropriately licensed health professional).

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

The Determination/Authorization requirements, timelines and procedures are published in the Provider Manual and are available on the www.MolinaHealthcare.com website.

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

Hospitals

Emergency Services means: As defined in 42 CFR 438.114, any Physical or Behavioral Health Covered Services (as described in Section 7.5.9) furnished by a qualified Provider in an emergency room that are needed to evaluate or stabilize an Emergency Medical Condition or a Psychiatric Emergency that is found to exist using the prudent layperson standard.

Emergency Medical Condition or Emergency means: As defined in 42 CFR 438.114, a medical or Behavioral Health condition, regardless of diagnosis or symptoms, manifesting itself in acute symptoms of sufficient severity (including severe pain) 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 individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or other due to an alcohol or drug abuse emergency, serious injury to self or bodily harm to others, or the lack of adequate time for a pregnant women having contractions to safely reach a another hospital before delivery. The Contractor may not impose limits on what constitutes an Emergency Medical Condition based only, or exclusively, on diagnoses or symptoms.

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 Healthcare.

Members accessing the emergency department inappropriately will be contacted by Molina Healthcare 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 Healthcare 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.

Inpatient Management

Elective Inpatient Admissions

Molina Healthcare 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 Healthcare requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. 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 inpatient 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 apprised of service requests and of the service provided to the Member by other Providers.

Inpatient Review

Molina Healthcare 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 Healthcare will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina Healthcare requires that requested clinical information updates be received by Molina Healthcare 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 Healthcare 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 Healthcare'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 Healthcare with Member demographic information, date of discharge, discharge plan and disposition.

Inpatient Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The inpatient 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 Healthcare 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. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Healthcare Member or there was a Molina Healthcare 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 Commonwealth requirements or Provider contracts that prohibit administrative denials supersede this policy.

Readmission Policy

Molina Healthcare will conduct readmission reviews for applicable participating hospitals if both admissions occur at the same facility. If it is determined that the subsequent admission is related to the first admission (“Readmission”), the first payment may be considered as payment in full for both the first and second hospital admissions.

Exceptions

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

Definitions

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

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

Non-Network Providers

Molina Healthcare maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care for Molina Healthcare Members. Molina Healthcare requires Members to receive medical care within the participating, contracted network of Providers 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 Healthcare. 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 Commonwealth Laws or regulations.

“Emergency Services” means: As defined in 42 CFR 438.114, any Physical or Behavioral Health Covered Services (as described in Section 7.5.9) furnished by a qualified Provider in an emergency room that are needed to evaluate or stabilize an Emergency Medical Condition or a Psychiatric Emergency that is found to exist using the prudent layperson standard.

Out of Network Services

In the event that a qualified specialist is not available within the contracted network, Molina Healthcare’s HCS staff will coordinate medically necessary services with an appropriately licensed and credentialed out-of-network (OON) specialist. Molina Healthcare will offer the OON Provider an opportunity to contract with the health plan, contingent upon the Provider’s meeting all credentialing standards.

Molina Healthcare provides coverage for new Members already receiving services from Out of Network (OON) Providers. Existing Members who require OON services or equipment due to medical necessity will be provided coverage under continuity of care. OON request is coordinated by the Molina Healthcare Care Coordinator, who partners with the Molina Healthcare UM regional partner to complete a Letter of Agreement (LOA) or contract, based on Member need.

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

Coordination of Care and Services

Molina Healthcare'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. In addition, the coordination of care process assists Molina Healthcare Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Healthcare Members whose benefits are ending and are in need of continued care.

Molina Healthcare 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 Healthcare staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

There are two (2) main coordination of care processes for Molina Healthcare Members. The first occurs when a new Member enrolls in Molina Healthcare and needs to transition medical care to Molina Healthcare contracted Providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member & Provider Contact Center (M&PCC) to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc. The second coordination of care process occurs when a Molina Healthcare Member's benefits will be ending and they need assistance in transitioning to other care. The process includes mechanisms for identifying Molina Healthcare Members whose benefits are ending and are in need of continued care.

Continuity of Care and Transition of Members

It is Molina Healthcare's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider

leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time 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 Healthcare or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina Healthcare at (888) 558-5501.

Organization Decisions

A decision is any determination (e.g., an approval or denial) made by Molina Healthcare 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 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 Commonwealth regulations when making decisions regarding appropriate medical treatment for Molina Healthcare Members. Molina Healthcare covers all services and items required by the Commonwealth.

Requests for authorization not meeting criteria must be reviewed by a designated Molina Healthcare Medical Director or other 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.

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.

Molina Healthcare reports suspected or potential abuse, neglect or exploitation of vulnerable adults as required by Commonwealth and Federal law. A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental/behavioral or emotional condition. Mandatory reporters include:

- Molina Healthcare employees who have knowledge or suspect the abuse, neglect, or exploitation;
- Law enforcement officer;
- Social worker; Professional school personnel; Individual Provider; an employee of a facility; an operator or a facility; and/or,
- An employee of a social service, welfare, mental/behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or health care Provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina Healthcare UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- Mental/behavioral mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.

- Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
- Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
- Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.

In the event that an employee of Molina Healthcare or one of its contracted Providers encounters potential or suspected abuse as described above, a call must be made to: **Departamento de la Familia 1-888-359-777. Departamento de la Familia Abuse Line 787 749-1333 and if is evidence of Physical Abuse call 911.**

All reports should include:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Any safety concerns.

Molina Healthcare's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities or other clinical personnel. Under Commonwealth 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 Healthcare 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 Healthcare will track, analyze, and report aggregate information regarding abuse reporting to the Utilization Management Committee and the proper Commonwealth agency.

Emergency Services

Emergency Services means: As defined in 42 CFR 438.114, any Physical or Behavioral Health Covered Services (as described in Section 7.5.9) furnished by a qualified Provider in an emergency room that are needed to evaluate or stabilize an Emergency Medical Condition or a Psychiatric Emergency that is found to exist using the prudent layperson standard.

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

Molina Healthcare accomplishes this service by providing a twenty-four (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina Healthcare contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals.

Continuity and Coordination of Provider Communication

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

Care Management

Molina Healthcare 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 the Member and all resources involved in the Member's care to develop an individualized plan of care which includes recommended interventions from Member's interdisciplinary care team. Individualized care plan interventions include links to appropriate institutional and community resources, to address medical and psycho-social needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager, 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

- 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 Healthcare Members. We may change them at any time as necessary to meet the needs of Molina Healthcare Members.

Health Education/Disease Management

Molina Healthcare 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
- Maternity Screening and High Risk Obstetrics

For more information about our programs, please call Molina Healthcare's Provider Services Department at (888) 558-5501, TTY/TDD at (787) 522-8281 (English). Visit www.MolinaHealthcare.com

Member Newsletters

Member Newsletters are posted on the www.MolinaHealthcare.com website at least 2 (two) 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 Healthcare 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 Healthcare 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 Healthcare HCS Department toll free at (888) 558-5501.

Case Management (CM)

Molina Healthcare 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 Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare case managers are licensed professionals and are educated, trained and experienced in the Care 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 Healthcare case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare 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 Care 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 Care Management and should be referred to the Molina Healthcare 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 (2) 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 Healthcare at:

Phone: (787) 999-6341

Fax: (855) 378-3641

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 Commonwealth and Federal 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 the Quality section of this Provider Manual. Medical records shall be maintained in accordance with Commonwealth, Centers for Medicare and Medicaid Services and Federal law, and for a period not less than ten (10) years.

Medical Necessity Standards

“Medically Necessary” or “Medical Necessity” A service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist in the Enrollee’s ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with Molina’s guidelines, policies and/or procedures.

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 Healthcare to be:

1. Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the patient’s medical condition;
2. Compatible with the standards of acceptable medical practice in the United States;
3. Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
4. Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care Provider;
5. Not primarily custodial care;
6. There is no other effective and more conservative or substantially less costly treatment service and setting available; and,
7. The service is not experimental, investigational or cosmetic in nature.

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 Healthcare 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.

Section 7. Quality

Quality Department

Molina Healthcare of Puerto Rico maintains a Quality Department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina Quality Department at (787) 200-3300.

The address for mail requests is:
Molina Healthcare of Puerto Rico, Inc.
Quality Improvement Department
654 Plaza, Suite 1600
654 Avenida Muñoz Rivera
San Juan, PR 00918

This Provider Manual contains excerpts from the Molina Healthcare of Puerto Rico Quality Improvement Program (QIP). For a complete copy of Molina Healthcare of Puerto Rico's QIP you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina Healthcare 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 Healthcare develops Quality Improvement activities for which Medical Group participation is expected. Molina Healthcare requires contracted Medical Groups to comply with the following core elements and standards of care and to:

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina Healthcare's Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process; and
- Allow access to Molina Healthcare Quality 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, 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 Healthcare 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 and must be signed by hand or electronically in a manner consistent with the EHR requirements. Molina Healthcare conducts a medical record review of all Primary Care Providers (PCPs) that have a fifty (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 and they must be duly signed.
- Record keeping is monitored for Quality and HIPAA compliance
- Storage maintenance for the determined timeline and disposal per record management processes
- Process for archiving medical records and implementing improvement activities

- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records

Content

Providers must demonstrate compliance with Molina Healthcare’s medical record documentation guidelines. Medical records are assessed based on the following standards:

- Patient name or ID is on all pages;
- Current biographical data is maintained in the medical record or database;
- All entries contain author identification, Authentication and signatures (electronic or written);
- All entries are dated;
- Problem list, including 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 are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Advanced Directives are documented for those twenty-one (21) years and older;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient’s presenting complaints and provides a risk assessment of the Member’s health status;
- Chronic conditions are listed or noted in easily recognizable location;
- Treatment plans are consistent with diagnosis
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient’s presenting complaints and provides a risk assessment of the Members health status;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- Encounter notation includes follow up care, call, or return instructions;
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted;
- A system is in place to document telephone contacts;
- Lab and other studies are ordered as appropriate and filed in chart;
- Lab and other studies are initialed by ordering Provider upon review;
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record; and
- If the Provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record;
- Developmental screenings as conducted through a standardized screening tool.

- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule and all EPSDT related services.
- Documentation of a pregnant Member's refusal to consent to testing for HIV infection and any recommended treatment.

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

Retrieval

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina for purposes of Quality;
- The medical record is available to ASES and the External Quality Review Organization upon request;
- The medical record is available to the Member upon their request;
- Medical record retention process is consistent with Commonwealth and Federal requirements and record is maintained for not less than ten (10) years; and,
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or Commonwealth 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 Commonwealth and Federal 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; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Additional information on medical records is available from your local Molina Healthcare Quality Department at (787) 200-3300. See also the Compliance Section of this

Provider Manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina Healthcare 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 providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on eighty percent (80%) 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 Healthcare Members in the timeframes noted:

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Adult Routine Physical Exams	Routine physical exams shall be provided for Enrollees age twenty-one (21) and over within thirty (30) Calendar Days of the Enrollee’s request for the service, taking into account both the medical and Behavioral Health need and condition.
Primary Care	Routine evaluations for Primary Care shall be provided within thirty (30) Calendar Days, unless the Enrollee requests a later time.
Covered Services	Covered Services shall be provided within fourteen (14) Calendar Days following the request for service.
Pediatric Routine Care	Periodic screens (“EPSDT Checkups”) in accordance with the Puerto Rico Medicaid Program’s periodicity schedule and the American Academy of Pediatrics EPSDT periodicity schedule.
Newly Enrolled/Newborn	Initial health and screening visits to all newly enrolled CHIP Eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth to all newborns; and, after the initial Checkup, annually.
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	“If this is an emergency, please hang up and dial 911.”
After-Hours Care	Available by phone twenty-four (24) hours/seven (7) days.
Behavioral Health	

Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care (Crisis)	Behavioral Health crisis services, face-to-face appointments shall be available within two (2) hours; and Detoxification services shall be provided Immediately according to clinical necessity.
Urgent Care	Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours.
Routine Care	Within ≤ ten (10) calendar days.
Other Providers	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Specialist	Specialist Services shall be provided within thirty (30) Calendar Days of the Enrollee's original request for service.
Dental Providers	Dental services shall be provided within sixty (60) Calendar Days following the request, unless the Enrollee requests a later date.
Diagnostic Laboratory, Diagnostic Imaging and Other Testing	<p>Diagnostic laboratory, diagnostic imaging and other testing appointments shall be provided consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Enrollee requests a later time.</p> <p>Diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the Enrollee wait time shall be consistent with severity of the clinical need.</p>
Prescription Fill Time	The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes. A prescription phoned in by a practitioner shall be filled within ninety (90) minutes.
Follow-up Visits	The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.
Urgent Diagnostic Laboratory, Diagnostic Imaging and Other Testing	Urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours.
Urgent Care Providers - Primary Medical, Dental	Primary medical, dental, and Behavioral Health Care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours.
Emergency Providers	Emergency Services shall be provided, including Access to an appropriate level of care, within twenty-four (24) hours of the service request.

Additional information on appointment access standards is available from your local Molina Healthcare Quality Department at (787) 200-3300.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed one hour. All PCPs are required to monitor waiting times and adhere to this standard.

Article 10 of Law number 194, supra, establishes the right of every patient to equal treatment, considerate and respectful on the part of the insurance companies and the Health care providers. In addition, article 14 of Regulation No 7617 of 21 November 2008 establishes that a demonstration of lack of respect for the patient, the waiting time of more than **one (1) hour** to receive health services, except for just cause, in which case the patient waiting in the office to be attended to, should be in knowledge to decide whether to wait or request a new appointment.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina Healthcare 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. If a second appointment is missed, the Provider is to notify the **Molina Healthcare Provider Services Department toll free at (888) 558-5501 or TTY/TDD 711**;
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language 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.
7. Preferential Turns to residents of Vieques and Culebra, refers to give priority in treating Members from these island municipalities, so that they may be seen within a reasonable time after arriving in the office. As established in Laws No. 86 enacted on August 16, 1997 (Arts. 1 through 4) and Law No. 200 enacted on August 5, 2004 (Arts. 1 through 5).

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 Healthcare must receive thirty (30) days advance written notice from the Provider.

Women's Health Access

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

Additional information on access to care is available from Molina's Quality Department at (787) 200-3300.

Monitoring Access Standards

Molina Healthcare monitors compliance with the established access standards above. At least annually, Molina Healthcare conducts an access audit of randomly selected contracted Provider offices to determine if appointment access standards are met. All appointment standards are addressed. Results of the audit are distributed to the Providers after its completion. A corrective action plan may be required if standards are not met. In addition, Molina Healthcare's Member Services Department reviews Member inquiry logs, Grievances and Appeals related to delays in access to care.

These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the Quality Department for review.

Additional information on access to care is available from Molina's Quality Department at (787) 200-3300.

Quality of Provider Office Sites

Molina Healthcare has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina Healthcare 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 Healthcare 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 Records heading) 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 Healthcare 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 Healthcare 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 Healthcare 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 Healthcare assesses one medical/treatment record for the areas described in the Medical Records section above. To ensure Member confidentiality, Molina Healthcare 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 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 Healthcare 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 injectable 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 Healthcare 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 Healthcare. 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 (6)-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 Healthcare Fair Hearing Plan policy.

Advance Directives (Patient Self-Determination Act)

Molina Healthcare 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 Providers and facilities uphold executed documents. Advance Directives are a written choice for health care.

Advance Directives are a written choice for health care. Law No. 160 of November 17, 2001, known as Preliminary Manifestation of Consent Act Regarding Medical Treatment in Case of Going Through a Terminal Health Condition or Persistent Vegetative State, acknowledges the right of each and every person, in full use of their mental capacity, to preliminary manifest his/her consent regarding medical treatment in case of going through a terminal health condition or persistent vegetative state, their requirements, effects, conditions, designation of an agent and other purposes. The Puerto Rico Supreme Court

in the case Luz E. Lozada Tirado, ET. Al. v. Roberto Tirado Flecha, ET. Al. (CC-2006-94 Certiorari) extended the right to appoint a representative and the prior decision regarding their healthcare, to any medical procedure or treatment. The rights extends to any other circumstances that may result in a limitation of the decision-making because of healthcare. You can appoint an agent and declare the will for your healthcare in case of any procedure or treatment.

By executing and advanced directive, and individual may determine whether and when his body may or may not be subjected to medical treatments in the event that his/her condition restrains him/her from personally stating such consent. Furthermore, the persona may pre-designate and agent, so that if he/she is unable to make decisions regarding a medical situation, such agent is enable to make decisions in his/her stead, considering the best interests of the beneficiary. In lieu of such designation, a family member can be designated by law, depending on the provisions of the regulation.

It is important for the beneficiary to know that it will be his/her responsibility to notify his/her doctor or the health services institution whether there is an advanced directive to provide them with a copy thereof. If the beneficiary comes to a persistent vegetative state, or is unable to communicate, one on the witnesses identified by the law, or the above mentioned designated agent, will notify the doctor. Once notified, the doctor will immediately attach a copy of said advanced directive to the medical record of the beneficiary.

You may revoke this document at any time in writing or orally. In case you want to modify it, you must do so in writing.

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 Healthcare Members (twenty-one [21] years old and up) of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other member communications such as newsletters and the Molina Healthcare website. If a member is incapacitated at the time of enrollment, Molina Healthcare will provide advance directive information to the Member's family or representative, and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services.

Molina Healthcare 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 Commonwealth specific to meet Commonwealth regulations.

Molina Healthcare 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 Healthcare 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 Healthcare'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.

Participating Providers are responsible for contacting new Members who are not compliant with EPSDT periodicity and immunization schedules for children as identified in the quarterly encounter list provided by Molina Healthcare. Providers should document reasons for noncompliance, where possible, and document efforts to bring the Member's care into compliance with the standards.

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, and accident and disease prevention);
- Tuberculosis (TB Test)
- Use of strips and lancets for members with Diabetes Type I

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

Monitoring for Compliance with Standards

Molina Healthcare 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 Healthcare 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 Healthcare 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 Healthcare'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 Healthcare 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 Healthcare Clinical Practice Guidelines include the following:

- Asthma
- Autism
- Cancer
- Coronary Artery Disease
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- High Blood Pressure/Hypertension
- Obesity
- Human Immunodeficiency Virus
- Behavioral Health
- Substance Abuse Disorders
- Serious Mental Illness
- Chronic Renal Disease- Level 1 and 2
- End Stage Renal Disease (ESRD)
- Multiple Sclerosis
- Rheumatoid Arthritis
- Hemophilia

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, bulletins and other media and are available on the Molina Healthcare website. Individual Providers or Members may request copies from Molina Healthcare's Quality Department at (787) 200-3300.

Preventive Health Guidelines

Molina Healthcare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), 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 zero to twenty-one (0-21) years old
- Care for adults twenty-one to sixty-four (21-64) 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 Healthcare 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 Healthcare's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

Molina Healthcare 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; and
- Effectiveness of Quality Improvement Initiatives.

Molina Healthcare 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 Healthcare 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 Healthcare's most recent results can be obtained from Molina's Quality Department at (787) 200-3300.

HEDIS®

Molina Healthcare 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, pre-natal visits, diabetes care, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare'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 Healthcare 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, Health Promotion and Education, Coordination of Care and Customer Service. 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 Healthcare's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

ECHO® Survey

The Experience of Care and Health Outcomes (ECHO®) 3.0 Survey is an NCQA® endorsed tool that assesses the experience, needs, and perceptions of Members with their behavioral health care. Similar to CAHPS®, the ECHO® survey for adults produce the following measures of patient experience:

- Getting treatment quickly
- How well clinicians communicate

- Getting treatment and information from the plan
- Perceived improvement
- Information about treatment options
- Overall rating of counseling and treatment
- Overall rating of the health plan

The ECHO® Survey will be administered annually to selected Members by an NCQA®-certified vendor.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods we use to identify improvement areas pertaining to the Molina Healthcare Provider Network. The survey results have helped establish improvement activities relating to Molina Healthcare’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 Healthcare 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 Healthcare also compiles complaint and appeals data as well as on requests for out-of-network services to determine opportunities for service improvements.

Section 8. 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:

- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- Claims Disputes/Reconsiderations
- Billing the Member
- Fraud and Abuse
- Encounter Data

Hospital-Acquired Conditions and Present on Admission Program

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

The following is a list of CMS Hospital Acquired Conditions. 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) Crushing Injuries
 - e) Burn
 - f) Other Injuries
- 6) Manifestations of Poor Glycemic Control

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

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and
- No additional payment will be made on Acute 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

Participating Providers are required to submit Claims to Molina Healthcare with appropriate documentation. Providers must follow the appropriate Commonwealth and CMS Provider billing guidelines. Providers must utilize electronic billing through a clearinghouse or Molina Healthcare’s Provider Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 81794. 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 Healthcare ID card.

Claims that do not comply with Molina's electronic Claim submission requirements will be denied.

Providers must bill Molina Healthcare 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 if electronic submission is not possible, please submit paper claims.

National Provider Identifier (NPI)

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

Electronic Claims Submission

Molina Healthcare strongly encourages Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Molina faster.

Molina Healthcare offers the following electronic Claims submission options:

- Submit Claims directly to Molina Healthcare via the [Provider Portal](#)
- Submit Claims to Molina Healthcare via your regular EDI clearinghouse using Payer ID 81794.

Provider Portal

Molina Healthcare’s Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

Clearinghouse

Molina Healthcare 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 Healthcare accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

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

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may 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

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

Molina Healthcare of Puerto Rico, Inc.
P.O. Box 364828
San Juan, PR 00936-4828

Coordination of Benefits and Third Party Liability

COB

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

Third Party Liability

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

Timely Claim Filing

Provider shall promptly submit to Molina Healthcare Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina Healthcare's

policies and procedures. Claims must be submitted by Provider to Molina Healthcare within ninety (90) calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina Healthcare is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina Healthcare within ninety (90) 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 Healthcare 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 Healthcare requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Molina Healthcare utilizes a claims adjudication system that encompasses edits and audits that follow Commonwealth and 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 Commonwealth benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the Commonwealth benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or Commonwealth benefit limit, the professional organization standard may be used.
 - In the absence of Commonwealth guidance, Medicare National Coverage Determinations (NCDs).
 - In the absence of Commonwealth guidance, Medicare Local Coverage Determinations (LCDs).
 - CMS Physician Fee Schedule Relative Value File (RVU) indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- Commonwealth-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 Commonwealth and Federal guidelines.
- Molina Healthcare 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 CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Provider acknowledges Molina Healthcare’s right to conduct post-payment billing audits. Provider shall cooperate with Molina Healthcare’s audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider’s charging policies, and other related data. Molina Healthcare shall use established industry Claims adjudication and/or clinical practices, Commonwealth, 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 Healthcare'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 *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1" "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

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 Healthcare or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within thirty (30) days after receipt of Clean Claims.

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 Healthcare uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment.

A Provider shall pay a Claim for an Overpayment made by Molina Healthcare which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a provider does not repay or dispute the overpaid amount within the timeframe allowed Molina Healthcare may offset the overpayment amount(s) against future payments made to the provider.

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

Provider Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within 90 days of Molina Healthcare's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Healthcare PR Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. *The form must be filled out completely in order to be processed.* Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following:

Providers should submit the following documentation:

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

Forms may be submitted via fax, secure email or mail. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address:

Molina Healthcare of Puerto Rico
Attention: Claims Disputes / Adjustments
PO Box 363849
San Juan, PR 00936-3849
Submitted via fax: **(895) 297-3306**

Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina Healthcare’s decision in writing within thirty (30) days of receipt of the Claims Dispute/Adjustment request.

If a Provider is not satisfied with the decision or resolution stated in the CRRF then the Provider have available the Provider Dispute Resolution Process and the timeframes applied are as follows:

Appeals Filing Timeframes

Action	Health Plan Resolution Time frame	Provider’s filing timeframe for the next level	Submission Process to the Health Plan
Grievances	Fifteen (15) calendar days	Fifteen (15) calendar days	Telephonic through the call center
1 st Level Appeal	Thirty (30) calendar days	Fifteen (15) calendar days	Provider Portal or Mail
2 nd Level Appeal	Fifteen (15) calendar days	Seven (7) calendar days	Provider Portal or Mail
3 rd Level Appeal	Seven (7) calendar days	Thirty (30) calendar days for an administrative law hearing with ASES	N/A

Providers can submit an appeal by mail to the following address:

Molina Healthcare of Puerto Rico
Attention: Provider Resolution Team / Adjustments
PO Box 363849
San Juan, PR 00936-3849

Submitted via Provider Portal: <https://provider.MolinaHealthcare.com>

Billing the Member

- Providers contracted with Molina Healthcare 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 Healthcare to the Provider
- Provider agrees to accept payment from Molina Healthcare as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Healthcare Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
 - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.

- The Member has been advised by the Provider that he/she is not contracted with Molina Healthcare and has documentation.
- The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

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 Healthcare 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 90 days from the date of service in order to meet Commonwealth 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 Healthcare 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 Healthcare. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial.

Molina Healthcare 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 Healthcare you should receive a 999 acknowledgement of your transmission.
- For Encounter submission you will also receive a 277CA response file for each transaction.

Section 9. Compliance

Fraud, Waste, and Abuse

Introduction

Compliance is a priority at Molina Healthcare of Puerto Rico. It is built into every level of our business. Our Compliance Program focuses on honesty, integrity, best practices and making ethical decisions while providing quality service to our members, providers, regulators and other business partners.

The Compliance Program is organized according to the elements of an effective compliance program, which are defined in federal law and incorporated into the US Department of Health and Human Services Office of Inspector General Compliance Program guidance.

Molina Healthcare of Puerto Rico, Inc. (Molina Healthcare) believes that implementation of a compliance plan benefits the company, its beneficiaries, employees, payors, and regulators by increasing efficiency, reducing waste, minimizing confusion and improving the quality of services. Molina Healthcare therefore has voluntarily adopted its compliance plan (Compliance Plan) with the approval of its Board of Directors.

Molina Healthcare regards the Compliance Program as an effective means of reaffirming Molina Healthcare's commitment to abide by and uphold the internal and external laws that govern Molina Healthcare and its activities.

I. Statement of Goals

- A. Molina Healthcare seeks to ensure compliance with all applicable laws and policies that govern Molina Healthcare's activities.
- B. Molina Healthcare seeks to ensure that Molina Healthcare representatives understand their legal and contractual responsibilities in this complex and highly regulated healthcare environment.
- C. Molina Healthcare seeks to ensure that requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and associated rules and regulations are met in an accurate and timely manner.
- D. Molina Healthcare seeks to assist Molina Healthcare representatives in understanding and performing their legal and contractual responsibilities in this complex and highly regulated healthcare environment.

Mission Statement

Molina Healthcare regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina Healthcare has therefore implemented a 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

On February 8, 2006, the Deficit Reduction Act (“DRA”) was signed into Law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare who receive or pay out at least \$5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and Commonwealth 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 the Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The

whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in disclosing or reporting a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare contracted Providers to ensure compliance with the Law.

Definitions

Fraud

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

Waste

Health care spending that can be eliminated without reducing the quality of care. Quality waste includes, overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. 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.

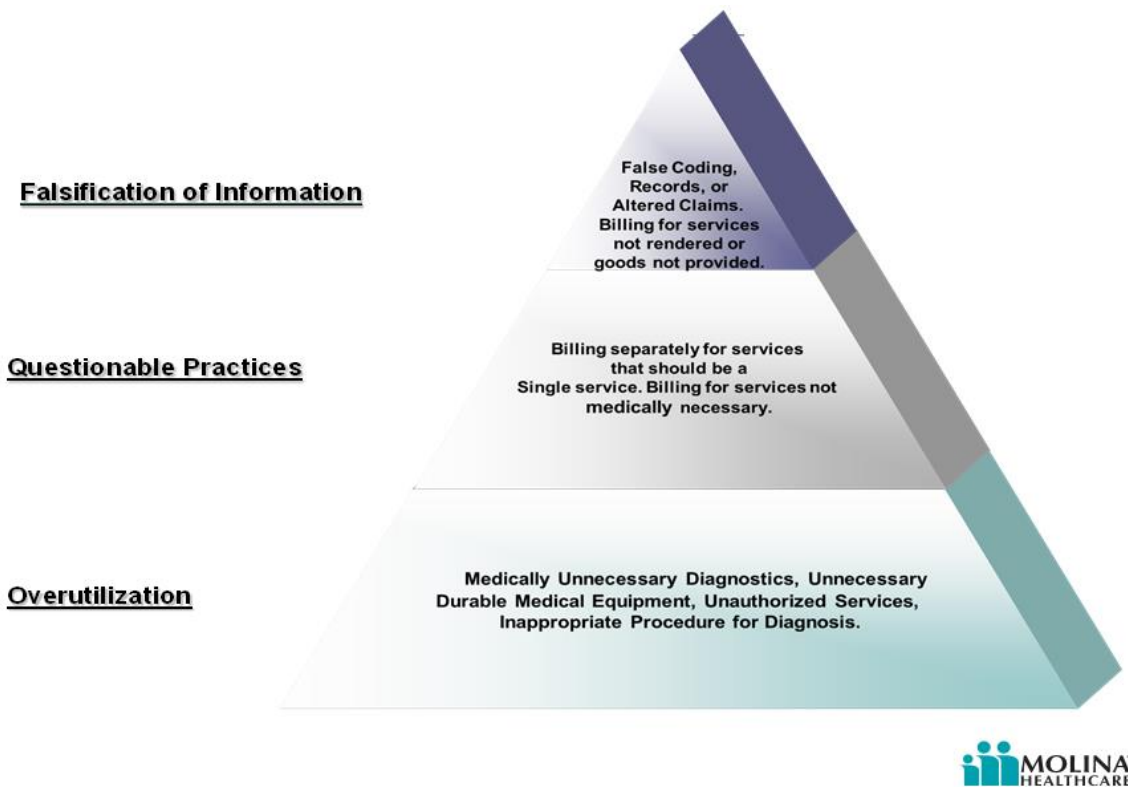
Abuse

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 physician knowingly and willfully referring a Medicaid patient to health care facilities in which or with which the physician 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 Healthcare 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 Healthcare Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that

Claims are processed accurately and ensure that payments reflect the service 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 Healthcare's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina Healthcare under the Provider Agreement or at Law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

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

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

Review of Provider

The Credentialing Department is responsible for monitoring Providers through the various Government reports, including:

- Commonwealth and Federal sanction reports.
- Commonwealth and Federal lists of excluded individuals and entities including the Puerto Rico ASES suspension/exclusion list.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible Provider list.
- Monthly review of Commonwealth Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate Government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Education

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

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

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year. When

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

Molina Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at <https://MolinaHealthcare.alertline.com>

You may also report cases of fraud, waste or abuse to Molina Healthcare of Puerto Rico's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Puerto Rico
Attn: Compliance
654 Plaza, Suite 1600
654 Avenida Muñoz Rivera
San Juan, PR 00918

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 Healthcare Member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the Commonwealth of Puerto Rico at:

The Health Insurance Administration (ASES), Toll Free Phone: (800) 981-2737; or, download the incident referral document which you can use to report fraud, waste, or abuse at: www.ases.pr.org.

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

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

Provider Responsibilities

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

Telehealth/Telemedicine Services: Telehealth transmissions conducted by Telehealth/Telemedicine Providers are subject to the Applicable Laws outlined in the following section:

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

Applicable Laws

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

1. Federal Laws and Regulations

- HIPAA
- The Health Information Technology for Economic and Clinical Health Act (HITECH)
- Medicare and Medicaid Laws
- The Affordable Care Act
- Title 42 Part 2, substance Use Disorder Confidentiality Regulations

2. Commonwealth Medical Privacy Laws and Regulations.

Providers should be aware that HIPAA provides a floor for patient privacy but that Commonwealth Laws should be followed in certain situations, especially if the Commonwealth 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 entity¹. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services²."
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; and,
 - 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.

Title 42 Part 2, Confidentiality of Substance Use Disorder Patient Records

Federal Substance Use Disorder Patient Confidentiality Regulations apply to federally assisted programs providing substance use disorder 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.

Inadvertent Disclosures of PHI

Molina Healthcare 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 Healthcare Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, unless otherwise permitted by Law.

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

²See 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 Commonwealth Law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

- 1. Notice of Privacy Practices**
Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
- 2. Requests for Restrictions on Uses and Disclosures of PHI**
Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
- 3. Requests for Confidential Communications**
Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
- 4. Requests for Patient Access to PHI**
Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
- 5. Request to Amend PHI**
Patients have a right to request that the Provider amend information in their designated record set.
- 6. Request Accounting of PHI Disclosures**
Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

7. Be treated with respect and with due consideration for the Enrollee's dignity and privacy.
8. Have all records and medical and personal information remain confidential.
9. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.
10. Participate in decisions regarding his or her health care, including the right to refuse treatment.
11. Request and receive a copy of his or her Medical Records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526.
12. Choose an Authorized Representative to be involved as appropriate in making care decisions.
13. Be free from harassment by the Contractor or its Network Providers with respect to contractual disputes between the Contractor and its Providers.
14. Participate in understanding physical and Behavioral Health problems and developing mutually agreed-upon treatment goals.

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 Healthcare requires the use of electronic transactions to streamline health care administrative activities. Molina Healthcare 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 Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina Healthcare's website at www.MolinaHealthcare.com for additional information regarding HIPAA standard transactions. (Details are located under the HIPAA tab.)

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina Healthcare within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina Healthcare.

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

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



AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name: _____ Member ID #: _____
Member Address: _____ Date of Birth: _____
City/State/Zip: _____ Telephone #: _____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

2. Name of persons/organizations authorized to receive the protected health information:

3. Specific description of protected health information that may be used/disclosed:

4. The protected health information will be used/disclosed for the following purpose(s):

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes _____ No _____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:

a) Action has been taken in reliance on this authorization; or,

b) If this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by Federal Law and regulations.

12. This authorization expires on the following date or event*: _____

*If no expiration date or event is specified above, this authorization will expire twelve (12) months from the date signed below.

_____ Signature of Member or Member's Personal Representative	_____ Date
_____ Printed Name of Member or Member's Personal Representative, if applicable.	_____ Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare.

Section 10. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina Healthcare) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina Healthcare 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 Commonwealth and Federal Law.

The Credentialing Program has been developed in accordance with Commonwealth 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. Urgent care services are medically necessary services, which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

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

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

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

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

Criteria for Participation in the Molina Network

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

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

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Application Provider must submit to Molina a complete, signed	<ul style="list-style-type: none"> ▪ Every section of the application is complete or designated N/A 	All Provider types	One-hundred-eighty (180)	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>and dated credentialing application.</p> <p>The application must be typewritten or completed in non-erasable ink. Application must include all required attachments.</p> <p>The Provider must sign and date the application attesting their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. If the Provider's attestation exceeds one-hundred-eighty (180) days before the credentialing decision, the Provider must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the Provider to update the attestation.</p> <p>If Molina or the Credentialing Committee requests any additional information or clarification, the Provider must supply that information in the period requested.</p> <p>Any changes made to the application must be initialed and dated by the Provider. Whiteout may not be used on the application rather the incorrect information must have a line drawn through it with the correct information written/typed</p>	<ul style="list-style-type: none"> ▪ Every question is answered ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision ▪ All required attachments are present ▪ Every professional question is clearly answered and the page is completely legible ▪ A detailed written response is included for every yes answer on the professional questions 		Calendar Days	

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>and must be initiated and dated by the Provider.</p> <p>If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina does not consider the associated attestation elements as present if the Provider did not attest to the application within the required period of one-hundred-eighty (180) days. If State regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation.</p> <p>The application and/or attestation documents cannot be altered or modified.</p>				
<p>License, Certification or Registration Provider must hold an active, current valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members.</p> <p>If a Provider has ever had his or her professional license/certification/registration in any State suspended or revoked or Provider has ever surrendered, voluntarily or involuntarily, his or her professional license/certification/registration in any State while under or to avoid</p>	<p>Verified directly with the appropriate State licensing or certification agency. This verification is conducted by one of the following methods:</p> <ul style="list-style-type: none"> ▪ On-line directly with licensing board ▪ Confirmation directly from the appropriate State agency. <p>The verification must indicate:</p> <ul style="list-style-type: none"> ▪ The scope/type of license ▪ The date of original licensure ▪ Expiration date ▪ Status of license ▪ If there have been, or currently are, any disciplinary action or 	<p>All Provider types who are required to hold a license, certification or registration to practice in their State</p>	<p>Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days</p>	<p>Initial & Recredentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct, Molina will verify all licenses, certifications and registrations in every State where the Provider has practiced.</p>	<p>sanctions on the license.</p>			
<p>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.</p> <p>If a Provider has a pending DEA/CDS certificate because of just starting practice or because of moving to a new State, the Provider may be credentialed on "watch" status provided that Molina has a written prescription plan from the Provider. This plan must describe the process for allowing another Provider with a valid DEA/CDS certificate to write all prescriptions requiring a DEA/CDS number.</p> <p>If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS certificate, the Provider may be considered for network participation if they submit a prescription plan for another Provider with a valid DEA or CDS certificate to write all prescriptions.</p>	<p>DEA or CDS is verified by one of the following:</p> <ul style="list-style-type: none"> ▪ On-line directly with the National Technical Information Service (NTIS) database. ▪ On-line directly with the U.S. Department of Justice Drug Enforcement Administration, Office of Diversion Control ▪ Current, legible copy of DEA or CDS certificate ▪ On-line directly with the State pharmaceutical licensing agency, where applicable <p>Written prescription plans:</p> <ul style="list-style-type: none"> ▪ A written prescription plan must be received from the Provider. It must indicate another Provider with a valid DEA or CDS certificate to write all prescriptions requiring a DEA number. ▪ Molina must primary source verify the covering Providers DEA. 	<p>Physicians, Oral Surgeons, Nurse Providers, Physician Assistants, Podiatrists</p>	<p>Must be in effect at the time of decision and verified within one-hundred-eighty (180) Calendar Days</p>	<p>Initial & Recredentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>If a Provider does not have a DEA because it has been revoked, restricted or relinquished due to disciplinary reasons, the Provider is not eligible to participate in the Molina network.</p>				
<p>Education & Training Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore, Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.</p>	<p>As outlined below under Education, Residency, Fellowship and Board Certification.</p>	<p>All Provider Types</p>	<p>Prior to credentialing decision</p>	<p>Initial & Recredentialing</p>
<p>Education Provider must have graduated from an accredited school with a degree required to practice in their specialty.</p>	<p>The highest level of education is primary source verified by one of the following methods:</p> <ul style="list-style-type: none"> ▪ Primary source verification of Board Certification as outlined in the Board Certification section of this policy. ▪ Confirmation from the State licensing agency when Molina has documentation that the State agency conducts primary source verification of the highest level of education and this confirmation is not greater than 12-months old. ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the education has specifically been verified. 	<p>All Provider types</p>	<p>Prior to credentialing decision</p>	<p>Initial Credentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	<ul style="list-style-type: none"> ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the education has specifically been verified. ▪ Confirmation directly from the accredited school. This verification must include the type of education, the date started, date completed and if the Provider graduated from the program. ▪ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. ▪ Association of schools of the health professionals, if the association performs primary-source verification of graduation from medical school and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ If a physician has completed education and training through the AMA's Fifth Pathway program, this must be verified through the AMA. 			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	<ul style="list-style-type: none"> ▪ Confirmation directly from the National Student Clearing House. This verification must include the name of the accredited school, type of education and dates of attendance. 			
<p>Residency Training Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Verification of the residency is always required except for General Providers as described in the General Provider section below.</p> <p>Molina only recognizes residency programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada.</p> <p>Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).</p> <p>Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to</p>	<p>Residency Training is primary source verified by one of the following methods:</p> <ul style="list-style-type: none"> ▪ Primary source verification of current or expired board certification in the same specialty of the Residency Training program (as outlined in the Board Certification section of this policy). ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified. ▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the 	<p>Oral Surgeons, Physicians, Podiatrists</p>	<p>Prior to credentialing decision</p>	<p>Initial Credentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>graduation from the program.</p>	<p>program was successfully completed.</p> <ul style="list-style-type: none"> ▪ Association of schools of the health professionals, if the association performs primary-source verification of residency training and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ For Closed Residency Programs, residency completion can be verified through the Federation of State Medical Boards Federation Credentials Verification Service (FCVS). ▪ For podiatrists, confirmation directly from the Council of Podiatric Medical Education (CPME) verifying podiatry residency program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed. 			
<p>Fellowship Training If the Provider is not board certified in the specialty in which they practice and has not completed a residency program they</p>	<p>Fellowship Training is primary source verified by one of the following methods:</p> <ul style="list-style-type: none"> ▪ Primary source verification of current 	Physicians	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.</p> <p>When a Provider has completed a Fellowship, Molina always completes either a verification of Board Certification or Verification of Residency in addition to the verification of Fellowship to meet the NCQA requirement of verification of highest level of training.</p>	<p>or expired Board Certification in the same specialty of the Fellowship Training program (as outlined in the Board Certification section of this policy).</p> <ul style="list-style-type: none"> ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified. ▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed. 			
<p>Board Certification Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not board certified may be considered for participation if they have satisfactorily completed a residency program from an accredited training</p>	<p>Board certification is primary source verified through one of the following:</p> <ul style="list-style-type: none"> ▪ An official ABMS (American Board of Medical Specialties) display agent, where a dated certificate of primary-source authenticity has been provided (as applicable). 	<p>Dentists, Oral Surgeons, Physicians, Podiatrists</p>	<p>Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days</p>	<p>Initial & Recredentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>program in the specialty in which they are practicing.</p> <p>Molina recognizes board certification only from the following Boards:</p> <ul style="list-style-type: none"> ▪ American Board of Medical Specialties (ABMS) ▪ American Osteopathic Association (AOA) ▪ American Board of Foot and Ankle Surgery (ABFAS) ▪ American Board of Podiatric Medicine (ABPM) ▪ American Board of Oral and Maxillofacial Surgery ▪ American Board of Addiction Medicine (ABAM) <p>Molina must document the expiration date of the board certification within the credentialing file. If the board certification does not expire, Molina must verify a lifetime certification status and document in the credentialing file.</p> <p>American Board of Medical Specialties Maintenance of Certification Programs (MOC) –Board certified Providers that fall under the certification standards specified that board certification is contingent upon meeting the ongoing requirements of MOC, no longer list specific end dates to board certification. Molina will list the certification as active without an expiration date and add the document in the credentialing file.</p>	<ul style="list-style-type: none"> ▪ AMA Physician Master File profile (as applicable). ▪ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File (as applicable). ▪ Confirmation directly from the board. This verification must include the specialty of the certification(s), the original certification date, and the expiration date. ▪ On-line directly from the American Board of Podiatric Surgery (ABPS) verification website (as applicable). ▪ On-line directly from the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM) website (as applicable). ▪ On-line directly from the American Board of Oral and Maxillofacial Surgery website www.aboms.org (as applicable). ▪ On-line directly from the American Board of Addiction Medicine website https://www.abam.net/find-a-doctor/ (as applicable). 			
General Practitioner	The last five years of work history in a	Physicians	One-hundred-	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>Providers who are not board certified and have not completed a training program from an accredited training program are <u>only</u> eligible to be considered for participation as a general Provider in the Molina network.</p> <p>To be eligible, the Provider must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.</p> <p>Molina will consider allowing a Provider who is/was board certified and/or residency trained to participate as a general Provider, if the Provider is applying to participate in one of the following specialties :</p> <ul style="list-style-type: none"> ▪ Primary Care Physician ▪ Urgent Care ▪ Wound Care 	<p>PCP/General practice must be included on the application or curriculum vitae and must include the beginning and ending month and year for each work experience. Any gaps exceeding six months will be reviewed and clarified either verbally or in writing. Verbal communication will be appropriately documented in the credentialing file. A gap in work history that exceeds 1 year will be clarified in writing directly from the Provider.</p>		<p>eighty (180) Calendar Days</p>	
<p>Advanced Practice Nurse Providers Advanced Practice Nurse Providers must be board certified or eligible to become board certified in the specialty in which they are requesting to practice.</p> <p>Molina recognizes Board Certification only from the following Boards:</p> <ul style="list-style-type: none"> ▪ American Nurses Credentialing Center (ANCC) ▪ American Academy of Nurse Providers Certification Program (AANP) ▪ Pediatric Nursing Certification Board (PNCB) 	<p>Board certification is verified through one of the following:</p> <ul style="list-style-type: none"> ▪ Confirmation directly from the board. This verification must include the specialty/scope of the certification(s), the original certification date, and the expiration date. ▪ Current copy of the board certification certificate including the specialty/scope of the certifications(s), the original certification date and the expiration date ▪ On-line directly with 	<p>Nurse Providers</p>	<p>One-hundred-eighty (180) Calendar Days</p>	<p>Initial and Recredentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<ul style="list-style-type: none"> ▪ National Certification Corporation (NCC) 	<p>licensing board, if the licensing primary verifies a Molina recognized board certification. License must indicate board certification/scope of practice.</p> <ul style="list-style-type: none"> ▪ Provider attests on their application to board certification including the specialty/scope of the certifications(s), the original certification date and the expiration date. 			
<p>Physician Assistants Physician Assistants must be licensed as a Certified Physician Assistant.</p> <p>Physician Assistants must also be currently board certified or eligible to become board certified the National Commission on Certification of Physician Assistants (NCCPA).</p>	<p>Board certification is primary source verified through the following:</p> <ul style="list-style-type: none"> ▪ On-line directly from the National Commission on Certification of Physician Assistants (NCCPA) website https://www.nccpa.net/. 	Physician Assistants	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing
<p>Providers Not Able To Practice Independently In certain circumstances, Molina may credential a Provider who is not licensed to practice independently. In these instances it would also be required that the Provider providing the supervision and/or oversight be contracted and credentialed with Molina. Some examples of these types of Providers include:</p> <ul style="list-style-type: none"> ▪ Physician Assistants ▪ Nurse Providers 	<ul style="list-style-type: none"> ▪ Confirm from Molina’s systems that the Provider providing supervision and/or oversight has been credentialed and contracted. 	Nurse Providers, Physician Assistants and other Providers not able to practice independently according to State law	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
<p>Work History Provider must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work</p>	<p>The credentialing application or curriculum vitae must include at least 5-years of work history and must include the beginning and ending</p>	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>as a health professional. If the Provider has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse Provider, clinical social worker) within the 5 years should be included.</p> <p>If Molina determines there is a gap in work history exceeding six-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file.</p> <p>If Molina determines there is a gap in work history that exceeds one-year, the Provider must clarify the gap in writing.</p>	<p>month and year for each position in the Provider's employment experience. If a Provider has had continuous employment for five years or more, then there is no gap and no need to provide the month and year; providing the year meets the intent.</p> <p>Molina documents review of work history by including an electronic signature or initials of the employee who reviewed the work history and the date of review on the credentialing checklist or on any of the work history documentation.</p>			
<p>Malpractice History Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the Provider on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</p>	<ul style="list-style-type: none"> ▪ National Provider Data Bank (NPDB) report 	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
<p>State Sanctions, Restrictions on licensure or limitations on scope of practice</p>	<ul style="list-style-type: none"> ▪ Provider must answer the related questions on the credentialing 	All Providers	One-hundred-eighty (180)	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>Provider must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Molina will also verify all licenses, certifications and registrations in every State where the Provider has practiced.</p> <p>At the time of initial application, the Provider must not have any pending or open investigations from any State or governmental professional disciplinary body.³ This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.</p>	<p>application.</p> <ul style="list-style-type: none"> ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The appropriate State/Federal agencies are queried directly for every Provider and if there are any sanctions, restrictions or limitations, complete documentation regarding the action will be requested. ▪ The NPDB is queried for every Provider. 		Calendar Days	
Medicare, Medicaid and other Sanctions	<ul style="list-style-type: none"> ▪ The HHS Inspector General, Office of 	All Providers	One-hundred-	Initial & Recredentialing

³ If a Provider's application is denied solely because a Provider has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the Provider may reapply as soon as Provider is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one (1) year from the date of original denial.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>Provider must not be currently sanctioned, excluded, expelled or suspended from any State or federally funded program including but not limited to the Medicare or Medicaid programs.</p> <p>Provider must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</p> <p>Provider must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</p>	<p>Inspector General (OIG) is queried for every Provider.</p> <ul style="list-style-type: none"> ▪ Molina queries for State Medicaid sanctions/exclusions/terminations through each State's specific Program Integrity Unit (or equivalent). In certain circumstances where the State does not provide means to verify this information and Molina has no way to verify State Medicaid sanctions/exclusions/terminations. ▪ The System for Award Management (SAM) system is queried for every Provider. ▪ The NPDB is queried for every Provider. 		eighty (180) Calendar Days	
<p>Professional Liability Insurance Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria as stated below unless otherwise stated in addendum B. This coverage shall extend to Molina Members and the Providers activities on Molina's behalf.</p>	<p>A copy of the insurance certificate showing:</p> <ul style="list-style-type: none"> ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage ▪ Either the specific 	All Provider types	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>The required limits are as follows:</p> <p>Physician (MD,DO) Nurse Provider, Certified Nurse Midwife, Oral Surgeon, Physician Assistant, Podiatrist = \$100,000/\$300,000</p> <p>All non-physician Behavioral Health Providers, Naturopaths, Optometrists = \$100,000/\$300,000</p> <p>Acupuncture, Chiropractor, Massage Therapy, Occupational Therapy, Physical Therapy, Speech Language Pathology = \$25,000/\$75,000</p>	<p>Provider name or the name of the group in which the Provider works</p> <ul style="list-style-type: none"> ▪ Certificate must be legible <p>Current Provider application attesting to current insurance coverage. The application must include the following:</p> <ul style="list-style-type: none"> ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage <p>Providers maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance. A copy of the Federal tort or self-insured letter or an attestation from the Provider showing active coverage are acceptable.</p> <p>Confirmation directly from the insurance carrier verifying the following:</p> <ul style="list-style-type: none"> ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical 			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	malpractice insurance <ul style="list-style-type: none"> ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage 			
<p>Inability to Perform Provider must disclose any inability to perform essential functions of a Provider in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</p> <p>An inquiry regarding inability to perform essential functions may vary. Molina may accept more general or extensive language to query Providers about impairments.</p>	<ul style="list-style-type: none"> ▪ Provider must answer all the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision 	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
<p>Lack of Present Illegal Drug Use Provider must disclose if they are currently using any illegal drugs/substances.</p> <p>An inquiry regarding illegal drug use may vary. Providers may use language other than "drug" to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances.</p>	<ul style="list-style-type: none"> ▪ Provider must answer all the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If the Provider discloses they are currently participating in a substance abuse monitoring program, Molina will verify directly with the applicable substance abuse monitoring program to ensure the Provider is compliant in the program or has 	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.</p>	<p>successfully completed the program.</p> <ul style="list-style-type: none"> ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision 			
<p>Criminal Convictions Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</p> <p>Provider must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.</p>	<ul style="list-style-type: none"> ▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If there are any yes answers to these questions, and the crime is related to healthcare, a national criminal history check will be run on the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision 	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
<p>Loss or Limitation of Clinical Privileges Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</p>	<ul style="list-style-type: none"> ▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The NPDB will be queried for all Providers. ▪ If the Provider has had disciplinary action related to 	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	clinical privileges in the last five (5) years, all hospitals where the Provider has ever had privileges will be queried for any information regarding the loss or limitation of their privileges.			
<p>Hospital Privileges Providers must list all current hospital privileges on their credentialing application. If the Provider has current privileges, they must be in good standing.</p> <p>Providers may choose not to have clinical hospital privileges if they do not manage care in the inpatient setting.</p>	The Provider's hospital privileges are verified by their attestation on the credentialing application stating the Provider has current hospital admitting privileges.	Physicians and Podiatrists	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
<p>Medicare Opt Out Providers currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.</p>	CMS Medicare Opt Out is queried for every Provider. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years and may not be contracted with Molina for any Medicare or Duals (Medicare/Medicaid) lines of business.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
<p>NPI Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).</p>	<ul style="list-style-type: none"> ▪ On-line directly with the National Plan & Provider Enumeration System (NPPES) database. 	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
<p>SSA Death Master File Providers must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.</p>	<ul style="list-style-type: none"> ▪ On-line directly with the Social Security Administration Death Master File database. 	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>If a Provider's Social Security number is listed on the SSA Death Master File database, Molina will send the Provider a conflicting information letter to confirm the Social Security number listed on the credentialing application was correct.</p> <p>If the Provider confirms the Social Security number listed on the SSA Death Master database is their number, the Provider will be administratively denied or terminated. Once the Provider's Social Security number has been removed from the SSA Death Master File database, the Provider can reapply for participation into the Molina network.</p>				
<p>Review of Performance Indicators Providers going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators.</p>	<p>Written documentation from the Molina Quality Department and other departments as applicable will be included in all recredentialing files.</p>	<p>All Providers</p>	<p>One-hundred-eighty (180) Calendar Days</p>	<p>Recredentialing</p>
<p>Denials Providers denied by the Molina Credentialing Committee are not eligible to reapply until one (1) year after the date of denial by the Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation.</p>	<ul style="list-style-type: none"> ▪ Confirmation from Molina's systems that the Provider has not been denied by the Molina Credentialing Committee in the past 1-year. 	<p>All Providers</p>	<p>One-hundred-eighty (180) Calendar Days</p>	<p>Initial Credentialing</p>
<p>Terminations Providers terminated by the Molina Credentialing Committee or terminated</p>	<ul style="list-style-type: none"> ▪ Confirm from Molina's systems that the Provider has not been terminated 	<p>All Providers</p>	<p>One-hundred-eighty (180) Calendar Days</p>	<p>Initial Credentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
<p>from the Molina network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation.</p>	<p>by the Molina Credentialing Committee or terminated from the Molina network for cause in the past 5-years.</p>			
<p>Validar si se incluyen las terminaciones con causa y sin causa</p>				
<p>Administrative denials and terminations Providers denied or terminated administratively as described throughout this policy are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation.</p>	<ul style="list-style-type: none"> ▪ Confirmation from Molina's systems if a Provider was denied or terminated from the Molina network, that the reason was administrative as described in this policy. 	<p>All Providers</p>	<p>One-hundred-eighty (180) Calendar Days</p>	<p>Initial Credentialing</p>
<p>Employees of Providers denied, terminated, under investigation or in the Fair Hearing Process Molina may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina.</p> <p>Molina also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from</p>	<p>When a Provider is denied or terminated from network participation or who is under investigation by Molina, it will be verified if that Provider has any employees. That information will be reviewed by the Credentialing Committee and/or Medical Director and a determination will be made if they can continue participating in the network.</p>	<p>All Providers</p>	<p>Not applicable</p>	<p>Initial and Re-credentialing</p>

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
network participation by Molina. For purposes of these criteria, a company is “owned” by a Provider when the Provider has at least five percent (5%) financial interest in the company, through shares or other means.				
ASSMCA “Administración de Servicios de Salud y Contra la Adicción” (if apply) Practitioners are required to hold a Current, valid ASSMCA Certificate.	ASSMCA is verified by: <ul style="list-style-type: none"> • Current, legible copy of ASSMCA certificate 	Physicians, Oral Surgeons, Dentist, Nurse Practitioners, Podiatrists, Among others	Must be in effect at the time of decision & verified within 180 Calendar Days	Initial, Re-credentialing & Annually
Professional College Membership “Colegiación” Law 77 of August 1994 mandates that the provider must be members of the Professional Affiliation	A current legible copy of the membership or Attested in the MHPR credentialing application.	Physicians & Healthcare Professionals	Annual	Initial, Re-credentialing & Annually
24 Hour Coverage If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24/7 services availability. The covering practitioner(s) must be qualified to asses over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day.	<ul style="list-style-type: none"> • Affirmative answer on the credentialing application indicating the practitioner has adequate 24-hour coverage. Documented phone call to the practitioner’s office clarifying the 24-hour coverage	Any practitioner performing invasive procedures.	180 Calendar Days	Initial & Re-credentialing

Section 11. Complaints, Grievance and Appeals Process

Definitions

What is a Complaint?

A Complaint is an expression of dissatisfaction about any matter other than an Action that is resolved at the point of contact rather than through filing a formal Grievance (see below for the definition of a Grievance).

For example, a Member can make a Complaint for incidents related to, but not limited to:

- Problems getting an appointment, or having to wait a long time for an appointment; or,
- Disrespectful or rude behavior by doctors, nurses or other Molina Healthcare clinic or hospital staff.

What is a Grievance?

A Grievance is a formal expression of dissatisfaction about any matter, other than an Action, that is documented and investigated by the plan.

What is an Appeal?

An Appeal is a formal request that the Member files with Molina Healthcare or the Patient Advocate Office when the Member does not agree with Molina Healthcare's determination (Adverse Benefit Determination) to deny, in whole or in part, a service, procedure, study, collection or payment.

What is an Administrative Law Hearing?

An Administrative Law Hearing is an appeal process, administered by the Commonwealth and as required by Federal law that is available to the Member after Molina Healthcare's internal Appeals process has been exhausted.

What is an Adverse Benefit Determination?

An Adverse Benefit Determination is a decision that Molina Healthcare makes that may affect the services the Member receives. Specifically, an Adverse Benefit Determination is:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service; or,
- The failure to provide services in a timely manner.

What is a Notice of Adverse Benefit Determination?

A Notice of Adverse Benefit Determination is a written notice provided by the Molina Healthcare to the member notifying the member of a Determination (as defined above). The Notice of Adverse Benefit Determination must contain the following information:

- The Determination Molina Healthcare has taken or intends to take;
- The reason(s) for the Determination;
- The Member's right to file an Appeal through Molina Healthcare's internal Grievance System and the procedure for filing an Appeal;
- The Member's right to request an Administrative Law Hearing after exhaustion of Molina Healthcare's Grievance System;
- The Member's right to allow a provider to file an Appeal or an Administrative Law Hearing on their behalf, upon written consent;
- The circumstances under which expedited review is available and how to request it;
- The Member's right to continue receiving benefits and covered services pending resolution of the Appeal with Molina Healthcare or during the Administrative Law Hearing; and,
- How the Member can request that benefits be continued and the circumstances under which the Member may be required to pay the costs of these services.

Molina Healthcare shall mail the Notice of Adverse Benefit Determination within the following timeframes:

- For termination, suspension, or reduction of previously authorized covered services, at least ten (10) calendar days before the date of Determination or no later than the date of Determination except in the event of one of the following exceptions:
 - Molina Healthcare has factual information confirming the death of an enrollee.
 - Molina Healthcare receives a clear written statement signed by the enrollee that he or she no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
 - The enrollee's whereabouts are unknown and the post office returns Molina Healthcare's mail directed to the enrollee indicating no forwarding address.
 - The enrollee's provider prescribes a change in the level of medical care.
 - Molina Healthcare may shorten the period of advance notice to five (5) calendar days before the date of Determination if it has facts indicating that the Determination should be taken because of probable enrollee fraud and the facts have been verified, if possible, through secondary sources.
- For denial of payment, at the time of any Determination affecting the claim.
- If Molina Healthcare extends the timeframe for the Authorization decision and issuance of Notice of Adverse Benefit Determination it shall give you written notice of the reasons for the decision to extend if you did not request the extension. Molina Healthcare shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.

What if the Member does not agree with the Notice of Adverse Benefit Determination?

If the Member does not agree with Molina Healthcare's determination included in the Notice of Adverse Benefit Determination, the Member has the right to appeal the determination before Molina Healthcare or the Patient Advocate Office within sixty (60) calendar days from the date of the Notice of Adverse Benefit Determination.

Member Grievance Process

How does a Member File a Complaint?

Members can file a Complaint by calling or writing Molina Healthcare. They can also visit one of Molina Healthcare's Service Centers to make their Complaint. The Member may authorize another person (such as a physician, relative or friend) to file a Complaint on their behalf. However, the authorization must be in *writing*. Molina Healthcare staff can assist Members who wish to file a Complaint.

The Member, or their authorized representative, must file a Complaint within fifteen (15) calendar days after the date of occurrence that initiated the Complaint. Molina Healthcare will resolve the Complaint within seventy-two (72) hours of receiving the initial Complaint, orally or in writing. If the Complaint is not resolved within this timeframe, the Complaint shall be treated as a Grievance.

Grievance Timelines

The Grievance can be presented in writing, by telephone or by visiting any of Molina Healthcare's Service Centers or the Patient Advocate Office. For example, the Member can file a Grievance for incidents related to, but not limited to:

- The quality of care or services provided
- Access to care or services
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Misinformation provided by Molina Healthcare or its providers
- Failure to respect your member rights
- Preauthorization requests
- Network provider changes
- Referrals
- Hazardous environment conditions

Member may file a Grievance with Molina Healthcare at any time. Molina Healthcare will acknowledge receipt of their Grievance in writing (and the authorized representative if applicable) within ten (10) business days of receipt.

Molina Healthcare will provide a written notice of how the Grievance was resolved as promptly as the Member's health condition requires, but in any event, within ninety (90) calendar days from the day we received the Grievance.

Members can call Molina Healthcare's Member Services Department toll free to file a Complaint or Grievance. Member Services is available from 7:00 a.m. to 7:00 p.m., Monday through Friday, to assist you. Please call 1-877-335-3305/TTY 1-787-522-8281.

Member Appeals Process

Standard Appeals Process and Timeline

Members have a period of sixty (60) calendar days to file a standard Appeal with Molina Healthcare after receipt of the Adverse Benefit Determination from Molina Healthcare. Molina Healthcare will review and make a decision on all standard Appeals as expeditiously as possible, but no later than thirty (30) calendar days from receipt. Members can call, write or visit Molina Healthcare's Service Centers to file an Appeal. However, if an Appeal is requested orally, it must be confirmed by the Member in writing within ten (10) calendar days of the oral filing.

The member's physician, a relative, or a person authorized by the Member can file the Appeal on their behalf; however, the Member's written consent is required. *If written confirmation of the Appeal request and/or written consent (when applicable) is not received, the Appeal will be closed and a decision will not be made.*

If the Appeal does not adversely affect the Member's health and/or does not put the Member's life at risk, the Member must receive the determination of the appeal within a period that does not exceed thirty (30) calendar days. However, if the Member's health condition requires an expedited determination; the Member will receive an answer within a period of seventy two (72) hours or less.

Molina Healthcare can request a fourteen (14)-day extension to send its determination, as long as this extension request benefits the Member or because the Member needs more time to find evidence or data that may benefit their case. If during the appeal process the Member request a continuation of services, the Member may be required to pay the cost of services furnished while the Appeal is still pending. This would be the case if the final decision is adverse to the Member.

Members can call Molina Healthcare's Member Services Department toll free to request an Appeal. Member Services is available from 9:00 a.m. to 5:00 p.m., Monday through Friday, to assist you. Please call 1-877-335-3305/TTY 1-787-522-8281. The Member may also fill out the Member Appeal Request Form and send via fax or mail directly to Molina Healthcare's Member Appeals and Grievance Department:

Expedited Appeals Process and Timeline

Members have the right to request an expedited review process for an Appeal if taking the time for a standard Appeal resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. The expedited

Appeal request will be reviewed to determine within seventy-two (72) hours if it meets the expedited appeal criteria. If the Member's condition does not meet the expedited review criteria, the Member will be promptly notified and the request will be treated as a standard appeal.

Expedited Appeal requests received orally do not require additional follow up in writing. However, written consent is required if the expedited appeal was requested by a third party on the Member's behalf.

Members can call Molina Healthcare's Member Services Department toll free to request an Appeal. Member Services is available from 9:00 a.m. to 5:00 p.m., Monday through Friday, to assist you. Please call 1-877-335-3305/TTY 1-787-522-8281. The Member may also fill out the Member Appeal Request Form and send via fax or mail directly to Molina Healthcare's Member Appeals and Grievance Department:

Fax: (844) 488-7053
Mail: Molina Healthcare of Puerto Rico, Inc.
ATTN: Member A&G Dept.
PO Box 365068
San Juan, PR 00936-5068

Review by Administrative Law Judge

If the Member is not satisfied with the outcome of the appeal after the Member has gone through Molina Healthcare's internal Appeal process for an Action; the Member can request an Administrative Law Hearing through ASES or the Health Advocate Office, or both, in a period not to exceed one hundred and twenty (120) calendar days from the date of Molina Healthcare's *Notice of Disposition of the Appeal*.

The Administrative Law Hearing resolution will be within ninety (90) calendar days of the date the Member filed an Appeal with Molina Healthcare for standard resolutions (not including the days it took you to file for an Administrative Law Hearing). For expedited resolution, the Administrative Law Hearing resolution will be within three (3) business days from ASES's receipt of a request for a hearing for a denial of service.

Before the Administrative Law Hearing, the Member and/or their authorized representative (or a representative of a deceased enrollee, if applicable) can request to look at and copy the documents and records Molina Healthcare will use at the Administrative Law Hearing or that the Member may otherwise need to prepare the case for the hearing. Molina Healthcare shall provide such documents and records at no charge to the Member.

Provider Claims Dispute (Adjustment Request)

The processing, payment or nonpayment of a Claim by Molina Healthcare shall be classified as a Provider Dispute and shall be sent to the following address:

Molina Healthcare of Puerto Rico
 Attention: Provider Resolution Team/Adjustments
 PO Box 363849
 San Juan, PR 00936-3849

Submitted via Provider Portal:
<https://provider.MolinaHealthcare.com>

Appeals Filing Timeframes

Action	Health Plan Resolution Time frame	Provider's filing timeframe for the next level	Submission Process to the Health Plan
Grievances	Fifteen (15) calendar days	Fifteen (15) calendar days	Telephonic through the call center
1 st Level Appeal	Thirty (30) calendar days	Fifteen (15) calendar days	Provider Portal or Mail
2 nd Level Appeal	Fifteen (15) calendar days	Seven (7) calendar days	Provider Portal or Mail
3 rd Level Appeal	Seven (7) calendar days	Thirty (30) calendar days for an administrative law hearing with ASES	N/A

Providers disputing a Claim previously adjudicated must request such action within ninety (90) days of Molina Healthcare's original remittance advice date.

Reporting

All Grievance/Appeal data, including Provider specific 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 Commonwealth of Puerto Rico 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 Healthcare 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 Healthcare 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.)

Section 12. Delegation

This section contains information specific to Molina Healthcare's delegation criteria. Molina may delegate certain administrative responsibilities upon meeting all of Molina Healthcare's delegation criteria. Molina Healthcare is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina Healthcare'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 Healthcare Delegation Oversight Manager.

Delegation Criteria

BH Crisis Line

To be delegated for BH Crisis Line functions, Providers (Delegates) must:

- Meet and comply with Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services ("CMS"), state requirements, federal requirements and Molina Healthcare policies and procedures, as applicable.
- Have a BH Crisis Line delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for BH Crisis Line.
- Correct deficiencies within the timeframes specified, when issues of non-compliance are identified by Molina Healthcare.
- Agree to Molina Healthcare's contract terms and conditions for BH Crisis Line delegates.
- Submit timely and complete BH Crisis Line reports to Molina Healthcare, as detailed in the Delegated Services Addendum (DSA) and/or as requested.
- Meet and comply with Delegation Services Addendum (DSA) and Molina Healthcare's BH Crisis Line Delegation Requirement Policy and Procedures.
- On audits, provide copies of recorded calls, as requested by Molina Healthcare.
- Comply with all applicable Laws and Regulations for BH Crisis Line.

Call Center

To be delegated for Call Center functions, Providers (Delegates) must:

- Meet and comply with Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services ("CMS"), state requirements, federal requirements and Molina Healthcare policies and procedures, as applicable.
- Have a Call Center delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Call Center.
- Correct deficiencies within the timeframes specified, when issues of non-compliance are identified by Molina Healthcare.
- Agree to Molina Healthcare's contract terms and conditions for Call Center delegates.

- Submit timely and complete Call Center reports to Molina Healthcare, as detailed in the Delegated Services Addendum (DSA) and/or as requested.
- Meet and comply with Delegation Services Addendum (DSA) and Molina Healthcare's Call Center Delegation Requirement Policy and Procedures.
- On audits, provide copies of recorded calls, as requested by Molina Healthcare.
- Comply with all applicable Laws and Regulation for Call Center.

Care Management

Care Management functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA) criteria for Case Management and Disease Management functions. To be delegated for Care Management functions, Providers (Delegates) must:

- Be certified by the National Committee for Quality Assurance (NCQA) for Case Management and/or Disease Management programs. If not certified, meet and comply with Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services ("CMS"), state requirements, federal requirements, NCQA and Molina Healthcare policies and procedures, as applicable.
- Development and implementation of a current Case Management and/or Disease Management program description in place.
- Have a Case Management and/or Disease Management delegation pre assessment audit, based on Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services ("CMS"), state requirements, federal requirements, NCQA and Molina Healthcare policies and procedures.
- Annual assessment and identification of Members needing Case Management services.
- Ongoing monitoring of Case Management plan, including evaluation of achieving goals and modifications to goals as necessary.
- Annual Member satisfaction surveys of the Case Management program, including analysis of results, identification for area(s) of improvement, and taking action on area(s) of improvement.
- Integration of Disease Management information with Member's other health information to ensure continuity of care.
- Correct deficiencies within the timeframes specified when issues of non-compliance are identified by Molina Healthcare.
- Agree to Molina Healthcare's contract terms and conditions for Case Management and/or Disease Management delegates.
- Submit timely and complete Case Management and/or Disease Management reports to Molina Healthcare, as detailed in the Delegated Services Addendum (DSA) and/or as requested.
- Meet and comply with Delegation Services Addendum (DSA) and Molina Healthcare's Case Management Delegation Requirement Policy and Procedures.
- On audits, provide copies of case files, as requested by Molina Healthcare.
- Meet and Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.

- Comply with all applicable Laws and Regulations for Case Management and/or Disease Management.

Claims Payment

Claims Payment delegates will be assessed on their ability to meet Molina Healthcare policies and procedures, State requirements, and/or Centers for Medicare and Medicaid Services (CMS) regulations prior to a delegation effective date and annually thereafter.

To be delegated for Claims, Providers (Delegates) must:

- Meet and comply with Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services (“CMS”), state requirements, federal requirements and Molina Healthcare policies and procedures, as applicable.
- Have a Claims delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Claims payment.
- Correct deficiencies within the timeframes specified when issues of non-compliance are identified by Molina Healthcare.
- Have a system capable of providing Molina Healthcare with the encounter data required by the state in a format readable by Molina Healthcare.
- Agree to Molina Healthcare’s contract terms and conditions for Claims delegates.
- Submit timely and complete Claims delegate reports to Molina Healthcare, as detailed in the Delegated Services Addendum (DSA) and/or as requested.
- Meet and comply with Delegation Services Addendum (DSA) and Molina Healthcare’s Claims Delegation Requirement Policy and Procedures.
- Provide Molina Healthcare with the encounter data required by the state in a format compliant with HIPAA requirements.
- Provide additional information as necessary to load encounter data, as requested by Molina Healthcare.
- 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 Delegation Services Addendum (DSA) and Molina Healthcare Claims Delegation Requirement Policy and Procedures.
- Comply with all applicable Laws and Regulations for Claims Payment.

Credentialing

Credentialing functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions. To be delegated for Credentialing functions, Providers (Delegates) must:

- Pass Molina’s credentialing pre-assessment, which is based on NCQA credentialing standards, Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services (“CMS”), state requirements, federal requirements and Molina Healthcare policies and procedures, as applicable.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.

- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG, SAM, and all published Commonwealth Medicaid exclusion lists within thirty (30) calendar days of the lists release by the reporting entity.
- 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) calendar days of the lists release by the reporting entity.
- Correct deficiencies within the timeframes specified 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 (DSA) and/or as requested.
- Meet and comply with Delegation Services Addendum (DSA) and Molina Healthcare’s Credentialing Delegation Requirement Policy and Procedures.
- On audits, provide copies of provider files, as requested by Molina Healthcare.
- Comply with all applicable Laws and Regulations for Credentialing and Recredentialing.
- 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:

Provider with current NCQA Credentials Verification Organization (CVO) Certification will still require a Pre Assessment Audit. Once current CVO Certification has been confirmed, the scope of the audit will be modified to include review of those elements and/or functions that NCQA does not review. This includes, but is not be limited to, the credentialing committee decision making process, the ongoing monitoring process, the appeals process, State Medicaid, Marketplace, CMS, and Health Plan policy and file requirements, and when applicable the HDO credentialing process and sub-delegation process.

Provider with current NCQA Health Plan Accreditation or Credentialing Certification will also still require a Pre-assessment Audit. Once Accreditation or Certification has been confirmed, the scope of the audit will be modified to include review of those elements and/or functions that NCQA does not review. This include, but not limited to, NCQA’s Practitioner Office Site Quality (CR5), Ongoing Monitoring (CR7), Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services (“CMS”), state requirements, federal requirements and Molina Healthcare policies and procedures and file requirements, as applicable.

Network Adequacy

To be delegated for Network Adequacy functions, Providers (Delegates) must:

- Maintain a Network Adequacy Program that in full compliance with applicable CMS, ASES, state requirements, federal requirements and Molina Healthcare policies and procedures, as applicable.
- Have a Network Adequacy delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Network Adequacy.
- Correct deficiencies within the timeframes specified when issues of non-compliance are identified by Molina Healthcare.
- Agree to Molina Healthcare's contract terms and conditions for Network Adequacy delegates.
- Submit timely and complete Network Adequacy reports to Molina Healthcare, as detailed in the Delegated Services Addendum (DSA) and/or as requested.
- Have required language in contracts with their providers.
- Comply with Delegation Services Addendum (DSA).
- On audits, provide information, as requested by Molina Healthcare.
- Comply with all Law and regulations for Network Adequacy.

Sanction Monitoring

To be delegated for Sanction Monitoring functions, Providers (Delegates) must:

- Have a Sanction Monitoring delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Sanction Monitoring. Have a screening process in place to review all the Providers employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) calendar days of the lists release by the reporting entity.
- Correct deficiencies within the timeframes specified when issues of non-compliance are identified by Molina Healthcare.
- Agree to Molina Healthcare's contract terms and conditions for Sanction Monitoring delegates.
- Submit timely and complete Sanction Monitoring reports to Molina Healthcare, as detailed in the Delegated Services Addendum (DSA) and/or as requested.
- Comply with Delegation Services Addendum (DSA) and Molina Healthcare Sanction Monitoring Delegation Requirement Policy and Procedure.
- On audits, provide document of OIG and SAM searches conducted on employees, as requested by Molina Healthcare.
- Meet and comply with Centers for Medicare & Medicaid Services (CMS), all applicable Law and regulations for Sanction Monitoring.

Utilization Management

Utilization Management functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA) criteria for Utilization Management functions.

To be delegated for Utilization Management functions, Providers (Delegates) must:

- Have a UM program that has been operational at least one year prior to delegation.

- Be NCQA accredited for utilization management or pass Molina Healthcare’s UM pre- assessment which is based on Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services (“CMS”), state requirements, federal requirements, NCQA and Molina Healthcare policies and procedures, as applicable, including but not limited to Federal requirements for Utilization Management (“UM”) including but not limited to 42 CFR. Part 456 and NCQA UM standards.
- Manage the use of a limited set of resources and maximize the effectiveness of care by evaluating clinical appropriateness, and authorizing the type and volume of services through fair, consistent, and Culturally Competent decision-making processes while ensuring equitable Access to care and a successful link between care and outcomes.
- Development and maintenance of the Provider’s UM program description, annual UM work plan, use of Board Certified consultants, and UM policies and procedures;
- Annual evaluation of UM Program Description, including identification of program strengths and weaknesses, and opportunities for improvement, UM work plan, and UM policies and procedure;
- Annual evaluation of UM decision criteria.
- Not permit or provide compensation or anything of value to its employees, Agents, or contractors based on:
 - Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or
 - Any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary Covered Service to any Enrollee, as set forth by 42 CFR 438.210(e).
- Comply with written policies and procedures for processing requests for authorizations of services in accordance with 42 CFR 438.210(b)(1).
- Correct deficiencies within the timeframes specified when issues of non- compliance are identified by Molina Healthcare.
- On audits, provide copies of UM case files, as requested by Molina Healthcare.
- Agree to Molina Healthcare’s contract terms and conditions for UM delegates.
- Submit timely and complete UM delegate reports to Molina Healthcare, as detailed in the Delegated Services Addendum (DSA) and/or as requested.
- Comply with Delegation Services Addendum (DSA) and Molina Healthcare Utilization Management Delegation Requirement Policy and Procedures.
- Meet and Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.
- Comply with all Law and Regulations for Utilization Management.

An entity may request certain administrative functions from Molina through Molina Healthcare’s Delegation Oversight Manager or through their Contract Manager. Molina Healthcare 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 responsibilities is based on the entity’s ability to

meet Administración de Seguros de Salud de Puerto Rico (ASES), Centers for Medicare & Medicaid Services (“CMS”), state requirements, federal requirements, NCQA and Molina Healthcare policies and procedures, as applicable to administrative function.

The Potential and/or current Providers (Delegates) shall not engage nor contract with a person or entity that is debarred or suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or a person or entity that is an Affiliate, as defined in FAR, of a such a person or entity (see 42 CFR 438.610).

All Potential and/or current Providers (Delegates) must fulfill the requirements of 42 CFR 438.3, 438.6 and 438.230 as appropriate. Potential and/or current Providers (Delegates) shall also retain, as applicable, Enrollee grievance and appeal records as per 42 CFR 438.416, base data for setting actuarially sound capitation rates as per 42 CFR 438.5(c), Medical Loss Ratio reports as per 42 CFR 438.8(k), and the data, information and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years, as set forth in Section 33.1.1 of the State Model Contract.

All Potential and/or current Providers (Delegates) must comply with the applicable 42 CFR part 438 requirements that pertain to the service or activity performed by the Potential and/or current Providers (Delegates).

Potential and/or current Providers (Delegates) must adhere, meet and comply with the Compliance section and where applicable, sections that are considered for delegation or presently delegated of this Provider Manual.

Potential and/or current Providers (Delegates) must fulfill and meet with requirements as set forth in Article 29 of the State Model Contract.

Potential and/or current Providers (Delegates) agree not to further sub-delegate administrative functions without written agreement from Molina Healthcare.

Delegation Reporting Requirements

Delegated entities contracted with Molina Healthcare must submit daily, weekly, monthly and/or quarterly reports determined by the function(s) delegated to the identified Molina Healthcare Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina Healthcare’s current delegation reporting requirements, please contact your Molina Healthcare Delegation Oversight Manager.

Section 13. Cultural Competency and Linguistic Services

Background

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

Additional information on cultural competency and linguistic services is available at www.MolinaHealthcare.com, from your local Provider Services Representative and by calling Molina Healthcare Provider Services at (888) 558-5501.

Nondiscrimination of Healthcare Service Delivery

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

Providers can refer Molina Healthcare 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 Healthcare Member need more information you can refer to the Health and Human Services website for more information:

<https://www.federalregister.gov/d/2016-11458>

Molina Healthcare Institute for Cultural Competency

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

Provider and Community Training

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

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

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

Integrated Quality Improvement – Ensuring Access

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

Molina Healthcare develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate

languages and formats, leading to better communication, understanding and Member satisfaction. Online materials found on www.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 Healthcare Member website.

Program and Policy Review Guidelines

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

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

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

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

24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than Spanish by calling Molina Healthcare's Contact Center toll free at (888) 558-5501. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a language service provider. Molina Healthcare Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Healthcare Members interpreter services if the Members do not request them on their own. It is never permissible to ask a family member, friend or minor to interpret.

Documentation

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

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

Members with Hearing Impairment

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

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

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

Nurse Advice Line

Molina Healthcare provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (888) 620-1515) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Section 14. Glossary of Terms

Action	The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.
Acute Inpatient Care	Care provided to persons sufficiently ill or disabled requiring: <ul style="list-style-type: none"> I. Constant availability of medical supervision by attending provider or other medical staff. II. Constant availability of licensed nursing personnel. III. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the provider.
Ambulatory Care	Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.
Ambulatory Surgical Facility	A facility licensed by the Commonwealth where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.
Ancillary Services	Health services ordered by a provider, including but not limited to laboratory services, radiology services, and physical therapy.
Appeal	A written request by a member or member's personal representative received at Molina Healthcare for review of an action.
ASES	Administracion de Seguros de Salud de Puerto Rico. The Puerto Rico Health Insurance Administration, the entity in the Commonwealth responsible for oversight and administration of the Government Health Program (GHP), or its Agent.
Authorization	Approval obtained by providers from Molina Healthcare for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.
Average Length of Stay (ALOS) –	Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.
Capitation	A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

Centers for Medicare & Medicaid Services (CMS)	A Federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.
Children's Health Insurance Plan (CHIP)	A Federal/Commonwealth funded health insurance program authorized by Title XXI of the SSA and administered by ASES.
Claim	A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.
Coordination of Benefits (COB)	Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.
Complaint	Any written or oral expression of dissatisfaction.
Covered Services	Medically necessary services included in the commonwealth contract. Covered services change periodically as mandated by federal or commonwealth legislation.
Credentialing	The verification of applicable licenses, certifications, and experience to assure that provider status be extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.
Current Procedural Terminology (CPT) Codes	American Medical Association (AMA) approved standard coding for billing of procedural services performed
Delivery System	The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers' offices and home health care.
Denied Claims Review	The process for providers to request a review of a denied claim.
Discharge Planning	Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.
Durable Medical Equipment (DME)	Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It is also equipment that is appropriate for use in the home and prescribed by a provider.
Electronic Data Interchange (EDI)	The electronic exchange of information between two or more organizations.
Early Periodic Screening Diagnosis and Treatment Program (EPSDT)	A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing,

	as well as any medically necessary services found during the EPSDT exam.
Emergency Care	The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).
Encounter Data	Molina Healthcare shall collect, and submit to HFS, enrollee service level encounter data for all covered services.
Excluded Providers	Excluded provider means an individual provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.
Expedited Appeal	An oral or written request by a member or member's personal representative received by Molina Healthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.
Expedited Grievance	A grievance where delay in resolution would jeopardize the member's life or materially jeopardize the member's health.
Federally Qualified Health Center (FQHC)	A facility which: <ul style="list-style-type: none"> • receive a grant under Section 329, 330 or 340 of the Public Health Service Act; or, • based on the recommendation of the Health Resources and Services Administration within the Public Health Service, are determined to meet the requirements for receiving such a grant.
Fee-For-Service (FFS)	FFS is a term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member.
GHP (Government Health Plan)	The government health services program (formerly referred to as Vital) offered by the Commonwealth of Puerto Rico, and administered by ASES, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health Services.
Grievance	An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at Molina Healthcare.

Health Plan Effectiveness Data and Information Set (HEDIS)	Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.
HIPAA	Health Insurance Portability and Accountability Act
Independent Practice Association (IPA)	A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.
Independent Review Organization (IRO)	A review process by a state/commonwealth- contracted independent third party.
Medicaid	The state/commonwealth and federally funded medical program created under Title XIX of the SSA.
Medical Emergency	Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the member's life or health would have been jeopardized had the care been delayed.
Medical Records	A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.
Medically Necessary	A service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist in the Enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the provider in accordance with Molina's guidelines, policies and/or procedures.
Medicare	The Federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts: <ul style="list-style-type: none"> • Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care. • Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.
Member	A current or previous member of Molina Healthcare.
NCQA	National Committee for Quality Assurance

Participating Provider	A provider that has a written agreement with Molina Healthcare to provide services to members under the terms of their agreement.
Preferred Provider Network (PPN)	A group of Network Providers that (i) GHP Enrollees may access without any requirement of a referral or Prior Authorization; (ii) provides services to GHP Enrollees without imposing any co-payments; and (iii) meets the appropriate Network requirements.
Primary Medical Group (PMG)	A grouping of associated Primary Care Physicians and other Providers for the delivery of services to GHP Enrollees using a coordinated care model. PMGs may be organized as Provider care organizations, or as another group of Providers who have contractually agreed to offer a coordinated care model to GHP Enrollees.
Provider Group	A partnership, association, corporation, or other group of providers.
Physician Incentive Plan	Any compensation arrangement between a health plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services to members under the terms of the agreement.
Preventive Care	Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.
Primary Care Provider (PCP)	A participating provider responsible 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 Practice providers, General Medicine providers, Internists, Obstetrician/Gynecologists, Physician Assistants (under the supervision of a Physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by Molina Healthcare.
Quality Improvement Program (QIP)	A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.
Remittance Advice (RA)	Written explanation of processed claims.
Referral	The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.
Rural Health Clinic (RHC)	A provider that has been designed by the Public Health Service, the US Department of Health and Human Services, or the Governor of Puerto Rico as a RHC.
Service Area	A geographic area serviced by Molina Healthcare, designated and approved by ASES.

Specialist	Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.
Supplemental Security Income (SSI)	A Federal cash program for aged, blind, or disabled persons, administered by the SSA.
Sub-Contract	A written agreement between a health plan and a participating provider, or between a participating provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.
Tertiary Care	Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.
Third Party Liability (TPL)	A company or entity other than Molina Healthcare liable for payment of health care services rendered to members. Molina Healthcare will pay claims for covered benefits and pursue a refund from the third party when liability is determined.
Title V	The portion of the federal SSA that authorizes grants to states/commonwealths for the care of CSHCN.
Title XIX	The portion of the federal SSA that authorizes grants to states/commonwealths for medical assistance programs. Title XIX is also called Medicaid.
Title XXI	The portion of the federal SSA that authorizes grants to states/commonwealths for CHIP.
TTY/TDD	Telecommunication Device for the Deaf.
Utilization Management (UM)	The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.