Provider Responsibility/Participation Requirements

Molina Healthcare of New Mexico, Inc. (Molina Healthcare) is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina Healthcare's Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina's Special Investigative Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies.

Anti-Fraud

What is Fraud?

An intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable federal or state law.

What is 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. Example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g., coding) causes unnecessary costs.

What is Abuse?

Provider practices that are inconsistent with sound fiscal, business or medical practices that result in unnecessary cost to the government program or in reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for health care

Provider Responsibility/Participation Requirements (*continued)*

Mission

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 detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Who Commits Health Care Fraud, Waste and Abuse?

Anyone can commit fraud, waste and abuse. The SIU will investigate any allegation involving a provider, Member, or other entity that is suspected of having committed health care fraud, waste or abuse. Molina Healthcare will seek criminal prosecution and/or civil damages in cases where fraud, waste or abuse may have occurred.

Provider Fraud, Waste, and Abuse Examples

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

- Altering claim forms, electronic claim forms, and/or or medical record documentation in order to get a higher level of reimbursement;
- Balance billing a Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated feeds, and the provider's usual and customary fees. provider
- Billing for a service using a credentialed/contracted provider when the provider who rendered services was not credentialed/contracted;[1]
- Billing and providing for services to Members that are not medically necessary;
- Provider Billing for services, procedures, and or/supplies that have not been rendered or provided;
- 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;
- Inappropriate billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement;
- Knowingly and willfully referring patients to health care facilities in which or with which the provider has a financial relationship for designated health services, which could be in violation of the Stark Law;
- 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;

[1] This does not impact locum tenens services that follow the appropriate guidelines.

Provider Responsibility/Participation Requirements (*continued)*

- Overutilization;
- Participating in schemes that involve collusion between a provider and a member that result in higher costs or charges;
- Questionable prescribing practices;
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code;
- Underutilization, which means failing to provide services that are medically necessary;
- Up-coding, which is when a provider does not bill the correct code for the service rendered, and instead uses a code for like services that cost more; and.
- Using the adjustment payment process to generate fraudulent payments.

Provider Responsibility/Participation Requirements (*continued)*

Member Fraud, Waste, and Abuse Examples

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

- Benefit sharing with persons not entitled to the Member's benefits;
- Conspiracy to defraud Medicaid or other government programs;
- Co-Payment evasion;
- 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;
- Identity theft;
- Improper coordination of benefits (e.g., Member fails to disclose multiple coverage policies);
- Inappropriately utilizing transportation benefit;
- Misrepresentation of status by providing false personal information in order to illegally receive a benefit;
- 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;
- Prescription stockpiling is when a Member attempts to inappropriately use his/her drug coverage by obtaining and storing large quantities of drugs to avoid out-of-pocket costs, to protect against period of non-coverage, or for purposes of resale on the black market;
- Polypharmacy abuse, which occurs when a Member is obtaining narcotics or other drugs from multiple pharmacies in order to cover-up his/her drug seeking behavior; and,
- Seeking services the Member is not eligible to receive.

Provider Responsibility/Participation Requirements (*continued)*

Cooperating with Special Investigative Unit Activities

Molina Healthcare's Special Investigative Unit (SIU) may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with SIU activities, and will provide requested documentation to the SIU following the timelines indicated in such requests. Failure to cooperate may result further action, up to and including termination of the provider contract.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must notify Molina Healthcare Compliance. Referring entities have the right to remain anonymously without fear of retaliation. Information reported to Compliance will remain confidential to the extent possible as allowed by law.

Molina Healthcare expressly prohibits retaliation against those, who in good faith, report potential fraud, waste and abuse. If you suspect health care fraud, waste and abuse, you may report the situation in writing or by telephone.

Molina Healthcare of New Mexico, Inc.
Attn: Compliance
P.O. Box 3887
Albuquerque, New Mexico 87190-9859
Confidential email: mhnm.compliance@molinahealthcare.com
Albuquerque: (505) 341-7469
Toll free Compliance/Anti-Fraud Program Hotline: (800) 827-2973
Toll free fax: (866) 472-4580

When reporting an issue, please provide as much information as possible. The more information provided to Compliance, the better the chances the situation will be successfully reviewed and resolved. Information that should be reported includes:

- Allegation – A complete description of the allegation, including the type of fraud, waste, or abuse (e.g., balance billing, falsification of information, billing for services not rendered).
- Suspect's Identity – The names, including any aliases or alternative names, of individuals and/or entities involved in suspected fraud, waste, or abuse, including address, telephone number, email address, Medicaid identification number, and any other identifying information.
- Dates of Occurrence – When did the fraud, waste, or abuse happen? Provide dates and times.

You may also report Medicaid fraud to:

Medical Assistance Division
Quality Assurance Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348
NMMedicaidFraud@state.nm.us

New Mexico Human Services Department
Office of Inspector General
Local in Albuquerque: (505) 827-8141
Toll free: (800) 338-4082
HSDOIGFraud@state.nm.us

Molina Healthcare of New Mexico, Inc. Salud services are funded in part under contract with the State of New Mexico

Provider Responsibility/Participation Requirements (*continued)*

Local in Santa Fe: (505) 827-3100
Toll free: (888) 997-2583

Medicaid Fraud Control Unit
111 Lomas NW, Suite 300
Albuquerque, NM 87102
Local in Albuquerque: (505) 222-9000
Toll free: (800) 678-1508

Provider Responsibility/Participation Requirements (*continued)*

Deficit Reduction Act (DRA)

The Deficit Reduction Act (DRA) of 2005 aims to cut fraud, waste, or abuse from the Medicare and Medicaid programs. Under the DRA, health care entities who receive or pay out at least $5 million in Medicaid funds per year must now comply with DRA Section 6032, Employee Education About False Claims Recovery. This section maintains that these entities must have written policies for all employees, contractors and agents that provide **detailed** information in terms of:

- The Federal False Claims Act and any state laws pertaining to civil or criminal penalties for false claims and statements, including whistleblower protections granted in these laws;
- How the provider will detect and prevent fraud, waste, and abuse; and
- The rights of the employee to be protected as whistleblowers and reiteration of the entity's policy for detecting and preventing waste, fraud, and abuse in the employee handbook.

The Federal False Claims Act, 31 USC § 3279, establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the United States government for payment or approval.

To better understand the intent of the Federal False Claims Act, terms like "knowing" and "knowingly" mean that a person, with respect to information:

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

The Federal False Claims Act also holds any person liable who engages in the following actions:

- Knowingly makes, uses or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved;
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;
- Has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the government or willfully conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receive a certificate or receipt;

Provider Responsibility/Participation Requirements (*continued)*

- Authored to make or deliver a document certifying receipt of property used, or to be used, by the government, and, intending to defraud the government, makes or delivers the receipt without completely knowing the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government who lawfully may not sell or pledge the property; or,
- Knowingly makes uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.

Persons who have engaged in the acts described are liable to the government for a civil penalty. The penalty is not less than $5,000 and not more than $10,000 plus three times the amount of damages the government sustains because of the act of that person. The only exceptions made would be if it were found the person who committed the violation furnished government officials responsible for investigating false claims violations with **all** information known about the violation within thirty (30) days after the date on which the person who committed the act first obtained the information. The violator must then fully cooperate with any government investigation. In addition, at the time the violator furnishes the government with the information about the violation, no criminal prosecution, civil action, or administrative action must have taken place, and the violator did not have actual knowledge of the existence of an investigation into the violation. In such a situation, the court would assess the matter at not less than two times the amount of damages. However, the violator would still be liable to the government for the costs of a civil action brought to recover any such penalty or damages.

It is important to note that the Act does not require proof of a specific intent to defraud the United States government or its agents. Health care providers and organizations can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims.

The State of New Mexico Medicaid False Claims Act (27-14-1 NMSA) became law in New Mexico on March 8, 2004. Like the Federal False Claims Act, the Medicaid False Claims Act has a Qui Tam "Whistleblower" provision with specific employee protections. The provision encourages employees (current or former) and other interested parties with information involving false claims to report these incidents to the government. The government may proceed to file a lawsuit against organizations accused of violating the False Claims acts on behalf of the individual who reported the violation. Or, the whistleblower may take this information and file a lawsuit on his/her own behalf. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

The Medicaid False Claims Act contains overlapping language in terms of a person's liability for certain acts. However, Article 14 differences, in terms of liability, are as follows:

- Presents or causes to be presented to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program;
- Knowingly applies for and receives a benefit or payment on behalf of another person, except pursuant to a lawful assignment of benefits, under the Medicaid program and converts that benefit or payment to his own personal use;

Provider Responsibility/Participation Requirements (*continued)*

- Knowingly makes a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program; or,
- Knowingly makes a claim under the Medicaid program for a service or product that was not provided.

Health care entities should also pay special note to Article 14 Section 7, civil action for false claims, and Section 9, Award to qui tam plaintiff. These sections describe in detail how the State may pursue civil actions against those who defraud the Medicaid system; and, the monetary awards whistleblowers may be entitled to for bringing a false claims issue to the attention of the government.

Employee protections are provided in Section 12. The section states employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to his/her role in furthering a false claims action are entitled to all relief necessary to make the employee whole. An employee turned whistleblower is entitled to:

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

By making health care entities responsible for putting these laws into practice within their business, these entities can no longer state they were not aware of false claims laws and what these laws mean.

Affected entities who fail to implement and comply with DRA Section 6032 will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare Compliance will monitor applicable Molina Healthcare providers to ensure they are complying with Section 6032 standards.

For more information on this legislation, please contact your Molina Healthcare Member Services Representative in Albuquerque at (505) 341-7493 or toll free at (888) 825-9266.

Together, our efforts can prevent fraud, waste and abuse.

Provider Responsibility/Participation Requirements (*continued)*

Sales/Gross Receipts Tax

Sales/Gross Receipts tax cannot be added to the charges of any patient who is a Member of a Health Plan or insurer of which a provider has made an agreement with to accept their reimbursement Division of Insurance Regulation, 13 NMAC 10.13.27.

Molina Healthcare has a policy of reimbursing our eligible contracted practitioners/providers an amount to offset the Gross Receipts Tax. The practitioner will need to provide Molina Healthcare with a copy of a recent Gross Receipts Tax filing to verify that the provider is eligible for this additional reimbursement.

Provider Responsibility/Participation Requirements (*continued)*

American Disabilities Act

It is the policy of Molina Healthcare to comply with the American Disabilities Act (ADA) enacted on July 26, 1990, which guarantees equal opportunity for individuals in public and private sectors service and employment. The practitioners/providers of medical care contracted with Molina Healthcare will not discriminate against Members in regards to the eligibility to enroll based upon health status or any physical or mental disability.

Members will receive and access medical care in a non-discriminatory fashion regardless of diagnosis or physical or mental limitations. Public Law 101-336, Section 36.304 requires public accommodations remove architectural barriers in existing facilities, i.e., easily accomplishable and able to be carried out without much difficulty or expense. It is the responsibility of both the building owner and/or landlord and the occupying tenant to comply with state and federal regulations.

Standards

Designated handicap parking must be:

- Available and at least one per facility;
- Placed at the shortest accessible route to the main entrance;
- A minimum of ninety-six (96) inches wide;
- Curb ramp must:
  - Be a minimum width of forty-eight (48) inches wide; and
  - Have space for parked vehicles must not obstruct use of ramp;
- Main entrance ramp must:
  - Be a minimum width of forty-eight (48) inches wide;
- Elevator must:
  - Be a minimum width of forty-eight (48) inches wide
- Water fountain must:
  - Be accessible with a paper cup dispenser or the office must have staff available to assist the Member in obtaining water.
- Restroom must:
  - Be handicap accessible or alternative access;
  - Have staff available to assist Member in accessing an inaccessible restroom; and
  - Have handrails installed.

Provider Responsibility/Participation Requirements (*continued)*

Cultural Competency and Diversity

Molina Healthcare practitioners/providers must be aware of and sensitive to the cultural, ethnic and linguistic needs of our Members.

As a contracted provider, you and your staff will receive orientation and information designed to facilitate communication with non-English speaking patients, patients who communicate using mechanisms other than spoken language, and patients who do not hold mainstream health beliefs. Molina Healthcare provides a translation line to assist with Molina Healthcare Members that do not speak English.

Practitioners/providers are encouraged to contact Molina Healthcare's Member Services Department to obtain assistance with our Members cultural, ethnic, and linguistic needs:

- Language Line – available during Molina Healthcare's business hours to assist with language barriers; and
- Provider Directory – practitioner gender & languages spoken published.

Please call our Member Services Department in **Albuquerque at (505) 341-7493 or toll free (888) 825-9266** and a Member Services Representative will assist you.

For additional cultural competency resources and tools, practitioners/providers are encouraged to visit our website www.molinahealthcare.com.

To obtain additional information, or a copy of our "Learn About Diversity" pamphlet, please contact the Provider Services Department in **Albuquerque at (505) 342-4660 or toll free at (800) 377-9594**. Several websites also offer insight into diversity issues. These include the American Medical Association www.ama-assn.org and the Association of American Medical Colleges www.aamc.org. To obtain a copy of Molina Healthcare's Cultural Competency Plan, please contact the Health Improvement Hotline in Albuquerque at (505) 342-4660 extension 182618 or toll free at (800) 377-5954 extension 182618.

On-Call Arrangements

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

Provider Responsibility/Participation Requirements (*continued)*

Provider/Member Clinical Dialogue

Molina Healthcare does not place limitations on clinical dialogue. Molina Healthcare encourages open communication regarding treatment the provider feels is in the best interest of the patient, regardless of whether or not the particular treatment would be covered by Molina Healthcare.

Billing and Compensation

The provider will not seek to collect, accept payment from, or bill Molina Healthcare Members any amounts except applicable co-payments or coinsurance for the provision of covered services over and above those paid for by Molina Healthcare.

Ensuring Appropriate Service and Coverage

It is the policy of Molina Healthcare that no one who makes decisions about whether health services are to be approved or denied is paid for denying those services or given any incentive for denying care or encouraging underutilization. Staff members are paid on a salaried basis. Reviewers who are not employees of Molina Healthcare are compensated only for the time they spend performing the reviews.

Disease Reporting

The provider will notify the State Office of Epidemiology **at (505) 827-0006** regarding confirmed or suspected communicable diseases, infectious diseases, and health conditions related to environmental exposures and certain injuries, sexually transmitted diseases and cancer.

The Individualized Education Program (IEP) & PCP Sign-offs

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

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

Provider Responsibility/Participation Requirements (*continued)*

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

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

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

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

Vaccines for Children Program

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

For information on enrolling with VFC, contact VFC at (888) 231-2367. **For more information, you can also see the New Mexico Immunization Program's website at www.health.state.nm.us/immunize/**

For more information on the New Mexico Statewide Immunization Information System to record immunizations administered in your clinic or healthcare facility, contact the NMSIIS website at http://www.health.state.nm.us/immunize/nmsiis.html

Advance Directives

It is the policy of Molina Healthcare to ensure that all Members have access to information regarding the right to make informed decisions about their medical treatment, even when they can no longer speak for themselves.

All provider office personnel with Member contact must maintain a general knowledge of this policy and the contents of the "Advance Directives" article text. Copies of the "Advance Directives" are included in this Section in English and Spanish.

For additional information, please call your designated Provider Services Representative.

Provider Responsibility/Participation Requirements (*continued)*

Request for Patient Medical or Treatment Records

It is sometimes necessary for Molina Healthcare to request medical records from a provider. Molina Healthcare staff will initiate requests for records from various departments including, but not limited to, the following: Claims, Utilization and Medical Management, Quality Improvement, Anti- Fraud Program, Complaints and Appeals, Credentialing, Finance, and Administration as the HIPAA minimum necessary rule dictates.

Molina Healthcare will reimburse the provider or his/her contracted vendor for copies of records requested, but not actually copied by Molina Healthcare and/or a Molina Healthcare vendor, and for collection of hybrid HEDIS® set data. **Payment will be made only according to strict criteria established by Molina Healthcare.**

Reimbursement will not be made for copies of records requested by Molina Healthcare staff for: utilization and medical management, care validation, anti-fraud program reviews, or suspected quality of care concerns.

Documentation in the Primary Care Medical Record

Standards for medical records have been developed to promote a consistent basis for documenting the provision of quality care and are in accordance with Regulatory and Accreditation requirements.

An underlying principle in Medical Record Documentation Standards is to ensure continuity of care. Well-documented medical records demonstrate that coordination of care is occurring. Whether electronic or on paper this documentation facilitates communication, coordination, and continuity of care while promoting the efficiency and effectiveness of treatment.

Elements include but are not limited to: problem lists, preventive health summary sheets, referrals, diagnostic results and detailed prescription history including name, amount, route, instructions, refills and review of the effectiveness of the medication in treatment. These standards allow a provider who is seeing a Member new to the provider an opportunity to effectively review case history upon meeting the Member.

Practitioners/providers shall maintain a medical record-keeping system that conforms with professional medical practice, permits effective internal and external quality review, permits encounter claim review, and facilitates an adequate system for follow-up treatment. All medical records should be maintained against loss or destruction and retained for at least ten (10) years.

In accordance with the HIPAA Privacy and Security Standards, practitioners/providers shall develop and implement appropriate safeguards to protect Member PHI. The provider shall maintain the confidentiality of the medical record information, assuring that the contents of the medical record will be released to only as required or permitted under applicable federal and state law and regulations.

Provider Responsibility/Participation Requirements (*continued)*

The provider shall cooperate with Molina Healthcare and its representatives for the purposes of audits and the inspection and examination of medical records and other activities under Molina Healthcare's Utilization Management, Quality Improvement and Compliance Programs.

Routine medical record audits are performed annually on selected PCPs and OB/GYN practitioner files. Documentation from selected facilities or specialists may be requested to conduct focused reviews relating to areas of non-compliance found during the auditing period. Practitioners/providers must maintain a compliance rating of eighty percent (80%) overall for medical record audits.

Practitioners/providers not achieving a threshold score of eighty percent (80%) may be required to develop a corrective action plan and a re-audit may be required. Re-audits not producing a significant improvement may jeopardize the provider's contract.

Audit results and educational materials addressing non-compliant areas will be sent to practitioners/providers within thirty (30) business days following the audit. Educational classes regarding medical record documentation are available upon request to the Quality Improvement Department of Molina Healthcare.

The following information is required in all Member records maintained by contracted practitioners/providers subject to the Members age, gender and history:

- Is the record in current detailed and organized?
- Is the patient's name or identifier on each page?
- Are personal biographical data and consent forms as required by Human Services Department (HSD) in the file? This includes a signed Statement of Notification of Privacy Practices (HIPAA).Is each date of entry and date of encounter noted? Is the practitioner's signature or electronic identifier on each note?
- Are allergies or adverse reactions noted or no known drug allergy (NKDA) or no known allergy (NKA)?
- Is there a past medical history for patients seen two or more times? Is the status of preventive health services summarized on a single sheet and up to date within six (6) months of enrollment? (Adult only) Are current problems identified? Is the patient screened for smoking? (≥ twelve 12 yo) (Age parameter per State of New Mexico 's Quality Assurance Bureau) Is the patient screened for alcohol use? If positive for abuse, is screening tool used? (≥ twelve [12] yo) (Age parameter per State of New Mexico 's Quality Assurance Bureau)
- Is the patient screened for substance abuse? (≥ twelve [12] yo) (Age parameter per State of New Mexico 's Quality Assurance Bureau)
- Are advance directive or a discussion about advanced directives being offered for adults (≥ 18 yo) in the file or noted? (Age parameter per the State of New Mexico Quality Assurance Bureau.) Is the record legible?
- Is there a History & Physical for the current complaints, including psychological and social conditions affecting the patient's medical and psychiatric status?
- Is the plan of treatment noted?
- Does the file show the patients medication history, what has been effective, what has not and why?
-

Provider Responsibility/Participation Requirements (*continued)*

- For drugs prescribed, does the practitioner note the name, strength, amount, directions for use and refills?
- Are follow-up plans for a return visit, and symptoms that should prompt a return visit documented? and
- Are new patients over age twenty-one (21) at first visit, screened for high-risk behavioral health conditions?

Coordination of Care Standards

- Does the PCP refer patients to behavioral health providers as appropriate? Are Specialty Practitioners reports in the patients file?
- Are diagnostic tests results in the patients file?
- Is there a note about the patient being told by the practitioner of abnormal results of any laboratory, imaging or other testing?
- Are reports of emergency care in the patient's file?
- Are therapeutic (physical therapy [PT], occupational therapy [OT], speech/language [SLP]) reports in the patient's file?
- Are home health nursing reports in the patient's file?
- Are hospital inpatient or discharge reports in the patient's file?
- Are surgery center reports in the patient's file? and
- Are nursing facility reports in the patients file?

Preventive Health Standards

- Were immunizations for adults offered as appropriate? (Flu, Pneumococcal, Tetanus & Varicella) Or is there a note that immunizations were offered and patient refused to consent and/or refused access to care?
- Has the patient had a Mammography in the last one to two years? (Females aged 40-69 years) Or is there a note that mammography was offered and patient refused to consent and/or refused access to care?
- Has the patient (females twenty-one [21]-sixty-five [65] years) had a Papanicolaou (PAP) in the last three (3) years? If the patient is at high risk, is there an annual PAP? If a PAP is not done, is there a note that the screen was offered and the patient refused to consent and/or refused access to care?
- Has the patient had a colorectal cancer screen by fecal occult blood in the last year, or colonoscopy or sigmoidoscopy or double contrast barium periodicity to be determined by the practitioner (Adults $\geq$ fifty [50] years old)? If screen not done, is there a note that the screen was offered and the patient refused to consent and/or refused access to care?
- Has the patient (over age eighteen [18]) received a blood pressure measurement at least every two (2) years? If screen not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Are all sexually active women age twenty-five (25) or younger screened for Chlamydia?

Provider Responsibility/Participation Requirements (*continued)*

- Are all female members over age twenty-five (25) who are considered at high risk (inconsistently use barrier contraception, have more than one (1) sex partner, or have had a sexually transmitted disease in the past) screened for Chlamydia? If the test not done is there a note that the screen was offered and the patient refused to consent and/or refused to access care?

Preventive Health Standards for Pregnancy

- Is the patient screened for preeclampsia in accordance with the most current American College of Obstetricians and Gynecologists (ACOG) recommendations? If not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Is the patient screened for Rh incompatibility in accordance with the most current ACOG recommendations? If Rh test not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?
- Is the patient's fetus screened for Down's syndrome and neural tube defects in accordance with the most current ACOG recommendations-Maternal Serum Alpha-Fetoprotein (MSAFP)? If test not done, is there a note that the screen was offered and refused (including refused to access care) or a note of "too late" as pregnancy is beyond twenty (20) weeks?
- Is the patient screened for hemoglobinopathies in accordance with the most current ACOG recommendations Hematocrit (H & H)? If H & H not done, is there a note that the screen was offered and the patient refused and/or refused to access care?
- Is the patient screened for vaginal and rectal group B streptococcal infection in accordance with the most current ACOG recommendations? If screen not done, is there a note that the screen was offered and the patient refused and/or refused to access care?
- Is the patient screened and counseled for Human Immunodeficiency Virus (HIV) in accordance with the most current ACOG recommendations? If screening and counseling not done, is there a note that the screen was offered and the patient refused to consent and/or refused to access care?

Provider Responsibility/Participation Requirements (*continued)*

Preventive Health Specific to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visits Up to the Age of Twenty-One (21)

- Is there a comprehensive health and developmental history, including assessment of physical and mental health development?
- Is there a comprehensive unclothed physical exam?
- Are there appropriate immunizations to age and history unless contraindicated? If immunizations are not done, is there a note that they were offered and refused (included refusal to access care), or is there documentation that copies of immunizations were requested and not brought in?
- Laboratory tests, including an appropriate lead blood level assessment at age one (1) and prior to two (2) years old.
- Is health education including anticipatory guidance documented?
- Are vision and hearing test orders and results documented?
- If not done, is there a note that the EPSDT or Well Child Check was offered and declined, or the patient/guardian chose not to access?

Preventive Health Services Provided to Children and Adolescents

Molina Healthcare encourages practitioners to use a preventive health documentation system such as that found at the end of this section to document preventive health services for patients under the age of twenty-one (21).

Practitioners/providers who have implemented a formal system for delivering preventive services increase his/her delivery in the clinical setting. There is also scientific evidence to support the effectiveness of using certain tools in a system to deliver preventive services - such as preventive care flow sheet, reminder notes on patient charts, and patient reminders. Molina Healthcare currently mails out such reminders through its monthly Patient Appointment Reminder Card for children and adults with corresponding practitioner panel reports.

Whether the practitioner chooses to use the forms recommended by Molina Healthcare (in this section), it is the responsibility of the practitioner to clearly document in the chart the completion of the five (5) components of the EPSDT screen for every EPSDT visit:

- Comprehensive health and developmental history;
- Comprehensive unclothed physical exam;
- Laboratory tests including blood lead screening;;
- Appropriate Immunizations;
- Vision and hearing tests: and

Provider Responsibility/Participation Requirements (*continued)*

- Health education including anticipatory guidance documentation. If not done, is there a note that the EPSDT or Well Child Check was offered and declined, or the patient/guardian chose not to access?

If any component of the above EPSDT screen is not completed, this must be noted in the medical record including whether the EPSDT or Well Child Check was offered and declined, or the patient/guardian chose not to complete the screen.

For more information about documentation of preventive health services provided to children, adolescents, and adults contact the Health Improvement Hotline in **Albuquerque at (505) 342-4660 extension 182618 or toll free at (800) 377-9594 extension 182618**.

For a more detailed description of EPSDT Program requirements, see Section N.

Member Rights and Responsibilities

Member Rights

1. Members or his/her legal guardians have a right to receive information about Molina Healthcare, Molina Healthcare's policies and procedures regarding products, services, its contracted practitioners/providers, grievance procedures, benefits provided and Members' rights and responsibilities.
2. Members have a right to be treated with courtesy and consideration, equitably and with respect and recognition of his/her dignity and right and need to for privacy.
3. Members or his/her legal guardians have a right to choose a PCP within the limits of the covered benefits, and plan network, and the right to refuse care of specific practitioners.
4. Members or his/her legal guardians have a right to receive from the Member's practitioner'(s), in terms that the Member or legal guardian(s) understands, an explanation of his/her complete medical condition, and recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives, irrespective of the health care insurer's or Molina Healthcare's position on treatment options. If the Member is not capable of understanding the information, the explanation shall be provided to his/her next of kin, guardian, agent or surrogate, if available, and documented in the Member's medical record.
5. Members have a right to receive health care services in a non-discriminatory fashion.
6. Members who do not speak English as his/her first language have the right to access translator services at no cost for communication with Molina Healthcare.
7. Members who have a disability have the right to receive information in an alternative format in compliance with the Americans with Disabilities Act.
8. Member or his/her legal guardians have a right to participate with his/her health care practitioners in decision making in all aspects of his/her health care, including the treatment plan development, acceptable treatments and the right to refuse treatment.
9. Member or his/her legal guardians shall have the right to informed consent.
10. Member or his/her legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.
11. Member or his/her legal guardians shall have the right to seek a second opinion by another provider in the Molina Healthcare's network when Members need additional information regarding recommended treatment or believe the provider is not authorizing requested care.
12. Members have a right to a candid discussion of appropriate or medically necessary treatment options for his/her conditions, regardless of cost or benefit coverage.
13. Member or his/her legal guardians have a right to voice complaints, grievances or appeals about Molina Healthcare, the handling of grievances, or the care provided and make use of Molina Healthcare's grievance process and the HSD hearings process, at no cost, without fear of retaliation.
14. Member or his/her legal guardians have a right to file a complaint, grievance or appeal with Molina Healthcare or, the HSD Administrative Hearings Bureau, for Medicaid Members, and to receive an answer to those complaints, grievances or appeals within a reasonable time.

Member Rights and Responsibilities (*continued)*

15. Member or his/her legal guardians have a right to choose from among the available practitioners/providers within the limits of Molina Healthcare's network and its referral and prior authorization requirements.
16. Member or his/her legal guardians have a right to make his/her decisions known through advance directives regarding health care decisions (i.e., living wills, right to die directives, "do not resuscitate" orders, etc) consistent with federal and state laws and regulations.
17. Member or his/her legal guardians have a right to privacy of medical and financial records maintained by Molina Healthcare and its practitioners/providers, in accordance with existing law.
18. Member or his/her legal guardians have a right to access the Member's medical records in accordance with the applicable federal and state laws and regulations.
19. Members have the opportunity to consent to or deny the release of identifiable medical or other information by Molina Healthcare, except when such release is required by law.
20. Members have a right to request an amendment to his/her Protected Health Information (PHI) if the information is believed to be incomplete or wrong.
21. Member or his/her legal guardians have a right to receive information about Molina Healthcare, its health care services, how to access those services, the network practitioners/providers (i.e., title & education, & the Patient Bill of Rights).
22. Member or his/her legal guardians have a right to be provided with information concerning Molina Healthcare's policies and procedures regarding products, services, practitioners/providers, appeal procedures, obtaining consent for use of Member medical information, allowing Members access to his/her medical records, and protecting access to Member medical information, and other information about Molina Healthcare and benefits provided.
23. Member or his/her legal guardians have a right to know upon request of any financial arrangements or provisions between Molina Healthcare and its practitioners/providers which may restrict referral or treatment options or limit the services offered to the Members.
24. Member or his/her legal guardians have a right to be free from harassment by Molina Healthcare or its network practitioners/providers in regard to contractual disputes between Molina Healthcare and practitioners/providers.
25. Member or his/her legal guardians have a right to available and accessible services when medically necessary as determined by the PCP or treating provider in consultation with Molina Healthcare, twenty-four (24) hours per day, seven (7) days per week for urgent or emergency care services and for other health care services as defined by the contract or evidence of coverage.
26. Members have a right to adequate access to qualified health professionals near where the Member lives or work within the service area of Molina Healthcare.
27. Members have a right to affordable health care, with limits on out-of-pocket expenses, including the right to seek care from a non-participating provider and an explanation of a Member's financial responsibility when services are provided by a non-participating provider or non-participating provider, or provided without required pre-authorization.
28. Member or his/her legal guardians have a right to prompt notification of termination or changes in benefits, services or provider network.

Member Rights and Responsibilities (*continued)*

29. Members have a right to seek care from a non-participating provider and be advised of their financial responsibility if they receive services from a non-participating provider, or receive services without required prior authorization.
30. Members have the right to continue an ongoing course of treatment for a period of at least thirty (30) days. This shall apply if the Member's provider leaves the provider network, or if a new Member's provider is not in the provider network.
31. Members have the right to make recommendations regarding the organization's Member rights and responsibilities policies.
32. Members have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
33. Member or his/her legal guardians shall have the right to select an MCO and exercise switch enrollment rights without threats or harassment.
34. Members have a right to detailed information about coverage, maximum benefits and exclusions of specific conditions, ailments or disorders, including restricted benefits and all requirements that an enrollee must follow for prior approval and utilization review.
35. Member or his/her legal guardians have all the rights afforded by law, rule, or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the Member understands.
36. Member or his/her legal guardians have the right to a complete explanation of why care is denied, an opportunity to appeal the decision to Molina Healthcare's internal review, the right to a secondary appeal, and the right to request the superintendent's or HSD's assistance as applicable.

Member Responsibilities

1. Member or his/her legal guardians have a responsibility to provide, to the extent possible, information that Molina Healthcare and its practitioners/providers need in order to care for him/her.
2. Member or his/her heir legal guardians have a responsibility to understand the Member's health problems and to participate in developing mutually agreed upon treatment goals.
3. Member or his/her legal guardians have a responsibility to follow the plans and instructions for care that he/she have agreed on with his/her practitioner(s).
4. Member or his/her legal guardians have a responsibility to keep, reschedule or cancel an appointment rather than to simply not show-up.
5. Member or his/her legal guardians have a responsibility to review his/her Member Handbook or Evidence of Coverage and if there are questions contact the Member Services Department for clarification of benefits, limitations and exclusions. The Member Services telephone number is located on the Member's Identification Card.

Member Rights and Responsibilities (*continued)*

6. Member or his/her legal guardians have a responsibility to follow Molina Healthcare's policies, procedures and instructions for obtaining services and care.
7. Member or his/her legal guardians have a responsibility to show his/her Member Identification Card each time he/she goes for medical care and to notify Molina Healthcare immediately of any loss or theft of his/her identification card.
8. Member or his/her legal guardians have a responsibility to advise a participating provider of coverage with Molina Healthcare at the time of service. Members may be required to pay for services if he/she does not inform the participating provider of his/her coverage.
9. Member or his/her legal guardians have a responsibility to pay for all services obtained prior to the effective date with Molina Healthcare and subsequent to termination or cancellation of coverage with Molina Healthcare.
10. Notify his/her Income Support Division Caseworker if there is a change in his/her name, address, telephone number, or any changes in his/her family.
11. Notify HSD and Molina Healthcare if he/she gets medical coverage other than through Molina Healthcare.
12. Member or his/her legal guardians have a responsibility to pay for all required co-payments and/or coinsurance at the time services are rendered.

Providing and Measuring Access to Medical Care

Introduction

Molina Healthcare is responsible for providing and maintaining appropriate access to primary medical care and services to all Members. Molina Healthcare is required to comply with access standards set forth by our regulators and the National Committee for Quality Assurance (NCQA). It is Molina Healthcare's policy to communicate established standards to all participating network practitioners/providers. Molina Healthcare monitors performance annually for each of these standards as part of our Quality Improvement Program. This enables Molina Healthcare to identify opportunities for improvement.

The following information contained in this section defines the minimum requirements of timely access to care. Participating network practitioners/providers are required to comply with Molina Healthcare's access standards.

Access Standards - Primary Care Services

A Primary Care Practitioner is defined as an individual, such as a physician or other qualified practitioner, who provides primary care services and manages routine health care.

Type of Appointment	Timeframe
Preventive Care - Asymptomatic	Within thirty (30) days
Routine Care – Symptomatic Primary Care Specialist	 Within fourteen (14) days Within twenty-one (21) days
Urgent Care	Within twenty-four (24) hours
After Hours Care	Twenty-four (24) hour coverage

Providing and Measuring Access to Medical Care (*continued*)

Appointment Availability Standards

Access Type	Request for Appointment or Wait Time
Routine, asymptomatic, Member-initiated, outpatient appointments for primary medical care	Request for appointment will be filled within thirty (30) days (unless the member requests a later time)
Routine asymptomatic, Member-initiated dental appointments	Request for appointment time shall be consistent with community norms for dental appointments
Routine, symptomatic, Member-initiated, outpatient appointments for non-urgent primary medical and dental care	Request for appointment will be filled within fourteen (14) days (unless the member requests a later time)
Primary medical and dental care, outpatient appointments for urgent conditions	Will be available within twenty-four (24) hours
Specialty outpatient referral and/or consultation appointments	Request for appointment will be consistent with the clinical urgency but no longer than twenty-one (21) days (unless the member requests a later time)
Routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments	Request for appointment will be consistent with the clinical urgency but no more than fourteen (14) days (unless the member requests a later time)
Outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, if a "walk in" rather than an appointment system is used	Wait time shall be consistent with severity of the clinical need
Urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments	The appointment shall be consistent with the clinical urgency, but no more than forty-eight (48) hours
Pharmacy Services	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
Durable Medical Equipment (DME) ▪ Urgent ▪ Non-urgent ▪ New customized or made to measure DME, or customized modifications to existing DME owned or rented by the Member ▪ DME repairs or non-customized modifications	▪ Shall be delivered within twenty-four (24) hours of the request ▪ Shall be delivered within a timeframe consistent with clinical need ▪ Shall be delivered within one hundred fifty (150) days of request ▪ Shall be delivered within sixty (60) days of request date
Transportation Services (contact ITM for scheduling and prior authorization)	Require forty-eight (48) hour notice Transportation for sudden, urgent situations may be arranged with less notice
Member Service Telephone Services ▪ Average Speed to Answer ▪ Average Abandonment Rate ▪ Answer ninety-five percent (95%) of Member calls	▪ ≤ Thirty (30) seconds ▪ ≤ Five percent (5%) ▪ ≤ Thirty (30) seconds

Providing and Measuring Access to Medical Care (*continued*)

Molina Healthcare is committed to providing its Members with accessible, timely, quality health care and services. Molina Healthcare monitors Member access to care through a number of mechanisms including:

- Annual After-Hours Telephone Survey: Practitioner offices are called after business hours to determine whether the call was answered by a live-person or a recording; whether or not emergency instructions were provided; and had sufficient means to speak with a practitioner;
- Annual Appointment Availability Survey: Telephone surveys are conducted annually to measure performance against Access Standards for Primary Medical Care Services;
- Annual Member Satisfaction Survey; conducted annually through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey;
- Ongoing Member Complaints Data: The rate of Member complaints relating to access and availability of care;
- Ongoing Report of Member Telephone Statistics: Molina Healthcare assesses the accessibility of Member services through ongoing measurements of average speed to answer; average abandonment rates; and percentage of calls answered within thirty (30) seconds or less; and
- Annual Healthcare Effectiveness Data and Information Set (HEDIS®) Access and Availability of Care Measures: These measures look at how Members access services from his/her health care delivery system, such as: adult's access to preventive/ambulatory services; children's access to PCPs; timeliness of prenatal and postpartum care; and annual dental visits.

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

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

Scheduling Appointments

Missed Appointments

If practitioners/providers should experience any problems with Members who fail to show for appointments, this information should be relayed to Member Services. Molina Healthcare will assist in educating the Member about the need to cancel or reschedule appointments prior to the time of his/her appointment.

The provider shall document missed appointments and mail or telephone recall efforts in his/her appointment system or the Member's medical record. If the office has a policy for accessing a charge for late cancellations or "no shows", the Children's Health Insurance Program Reauthorization Act (CHIPRA) Member is responsible for such charges, as allowed by regulation. ***However, Salud Members cannot be charged for cancellations or "no shows."***

Primary Care Practitioner (PCP)

Choosing a PCP

At the time the Member is added to Molina Healthcare, a PCP will be assigned to the Member. The Member will receive an identification card showing the assigned PCP. The Member has the right to change that PCP, and may call Molina Healthcare with the change.

PCPs are chosen from the list of participating practitioners in one of the following specialties:

- Family Practice, General Practice;
- Certified Nurse Practitioner;
- Internal Medicine;
- Pediatrics; and
- OB/GYN – Female Members may self-refer to a women's health care provider. Some OB/GYNs act as a PCP. In this case, the OB/GYN is listed under the Primary Care Section of the Provider Directory. Individual family Members may choose the same or different PCPs.

The Member has the right to change that PCP and may call Molina Healthcare with the change request. If a Member changes PCPs, Molina Healthcare will issue a new card to the Member. Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the twentieth (20^{th}) of the month, it will become effective the first day of the following month. If the request is made after the twentieth (20^{th}) day, it will become effective the first (1^{st}) day of the second (2^{nd}) month following the request.

The PCP is responsible for serving as the manager of all health care provided to the Members who have selected him/her.

The PCP's responsibilities as the manager of Member care are as follows:

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

Primary Care Practitioner (PCP) (*continued*)

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

Specialty Provider

Services from a Specialty Provider

When the PCP determines that a Molina Healthcare Member needs to see a specialist, the PCP initiates a referral. ***Referral information is located in Section I.***

It is important for specialty practitioners/providers to advise the PCP when follow-up care is necessary. The specialty provider may treat as necessary within the parameters of the referral from the PCP that are appropriate (i.e. lab tests, radiology, therapies, etc.). If the Member requires a procedure for which prior authorization is required, including hospitalization, the specialty provider is responsible for obtaining the proper authorization from Molina Healthcare.

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

Primary Care Practitioner (PCP) (*continued*)

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

Under certain circumstances, and with prior approval, a specialist can act as the Member's PCP for some chronic or long term care conditions. Call the Provider Services Department toll free at (800) 377-9594 for more information.

Emergencies

Emergency Care

Molina Healthcare defines a medical emergency as a condition that manifests itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a reasonable layperson to result in: (a) jeopardy to the Member's health; or (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part; or (d) disfigurement of the person. Emergency services may be provided for, but are not limited to heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and accidental injuries. Some conditions should **NOT** be treated in an emergency setting. Emergency rooms (ER) are designed to deliver emergency care only.

PCP Role in Emergency Situation

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

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

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

Out-of-Area Emergencies

Coverage for out-of-area emergencies is provided only for true emergency situations - those which could not have been anticipated. Routine medical services are not covered when provided outside the service area.

Emergencies (*continued*)

Members are instructed to seek care at the nearest appropriate facility such as a clinic, urgent care center, or hospital ER.

When notified of an out-of-area emergency, which requires follow-up or has resulted in an inpatient admission, the PCP is expected to monitor the Member's condition, arrange for appropriate care, and determine whether the Member can be safely transferred to a participating hospital.

PCP Initiated Member Changes

Molina Healthcare realizes that occasionally, a provider may feel that due to certain circumstances, a patient should receive care from another provider. Molina Healthcare has developed policies that are meant to give clear guidelines on how to document and address the situation with Molina Healthcare Members.

When all reasonable efforts have been made to accommodate the Member and reasonable cause for the request for a Member to change practitioners/providers has been established, a practitioner may initiate that change. Molina Healthcare defines reasonable cause as any situation where a Member's behavior toward the practitioner or the office staff is such that it is not feasible to safely or prudently provide medical care. Examples include:

- If the practitioner feels threatened by, or has been threatened by the Member;
- If the practitioner is unable to collect co-pays due from the Member;
- If the Member does not keep scheduled appointments and does not notify the PCP within a reasonable time of the appointment cancellation;
- If a Member has initiated legal actions against the practitioner; and
- If the Member is routinely non-compliant with suggested treatments.

Reasonable Cause Does Not Include a Member's Health Status

Molina Healthcare asks that you document the need for these changes in writing to the Provider Services Department, with the specific reasons for the request. You can send your documentation to:

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

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

Changes in Provider Status

Practitioners Joining or Leaving a Practice

Any practitioner changes (i.e. joining or leaving a practice) must be communicated to the appropriate Molina Healthcare Provider Services Representative. These changes take time to complete and should be initiated at least four (4) weeks prior to the actual date of the change.

When Joining a Practice:

- Contact your Molina Healthcare Provider Services Representative to complete the required Molina Healthcare application; and
- Sign the appropriate contractual agreement, if necessary.

Provider Termination:

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

When Terminating as a Contracted Practitioner with Molina Healthcare:

- Notify your Provider Services Representative in writing;
- The Provider Services Representative will remove the terminating provider from the next printing of the Provider Directory and will ensure termination of the provider in the Molina Healthcare's claims processing system;
- Molina Healthcare's Enrollment Department will notify Members of PCP changes. A Member assigned to a terminated PCP will be given adequate time to select a new PCP. If a new PCP is not selected, one will be assigned to him/her from a list of participating PCPs in his/her geographic area that is accepting new patients.

Change of Address:

- Notify your Provider Service Representative in writing as soon as you know your new address.

Open/Closed Panel:

For PCPs, "Open Panel" indicates the practice is accepting new Members. "Closed Panel" indicates the practice is not accepting new Members. You must allow thirty (30) days notification of this change. Please notify your Provider Services Representative in writing.

Changes in Provider Status (*continued*)

Transition of Care After Termination

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

- Not bill any Molina patients in this ninety (90) transition period for Covered Services with the exception of any applicable Copayments, Deductibles and/or Coinsurance;
- Will accept the contracted rate reflected in the Agreement as payment in full during the ninety (90) Day transition period or until such time as the Molina patient's episode of care is resolved or is transitioned to another contracted Molina Healthcare provider;
- Will continue to follow Molina Healthcare's Utilization Managed policies and procedures; and
- Will share any information requested, included medical records, regarding the treatment plan with Molina Healthcare.