PROVIDER MANUAL

Molina Healthcare of Washington

Apple Health Medicaid

2021

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at www.MolinaHealthcare.com.

Last Updated: 01/01/2021

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1. Addresses and Phone Numbers

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

Member and Provider Contact Center

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

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

Claims

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

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

Claims Recovery Department

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

Claims Recovery Disputes and Refunds
Refunds Address: Molina Healthcare of Washington, Inc. PO Box 30717 Los Angeles, CA 90030-0717
Disputes Molina Healthcare of Washington, Inc. PO Box 2470 Spokane, WA 99210-2470
Phone: (866) 642-8999
Fax: (888) 396-1520

Contracting Department

The Contracting department should be contacted if you are interested in contracting with Molina Healthcare or adding a provider to an already contracted group that requires credentialing and status on either of these requests. Please email the Add Provider/Mini Application Form for new requests.

Contracting Department
Address: Molina Healthcare of Washington, Inc. PO Box 4004 Bothell, WA 98041-4004
e-mail: MHWProviderContracting@MolinaHealthcare.com

Provider Information Team

The provider information team should be contacted for demographic updates such as: new billing or service locations addresses, TIN changes, adding a provider to a group that does not require credentialing as well as individual provider and group terminations.

Please email the appropriate form below for demographic updates to MHWProviderInfo@MolinaHealthcare.com:

Provider Change Form

Termination Notification Form

Credentialing Department

The Credentialing Department verifies all information on the Washington Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a

Provider's qualifications to participate in the Molina Healthcare network. The Credentialing Department also performs office and medical record reviews.

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

24-Hour Nurse Advice Line

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

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

Healthcare Services (Authorization Department)

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

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

Advanced Imaging Fax: (877) 731-7218

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

Pharmacy Department

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

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

Caremark Pharmaceuticals

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

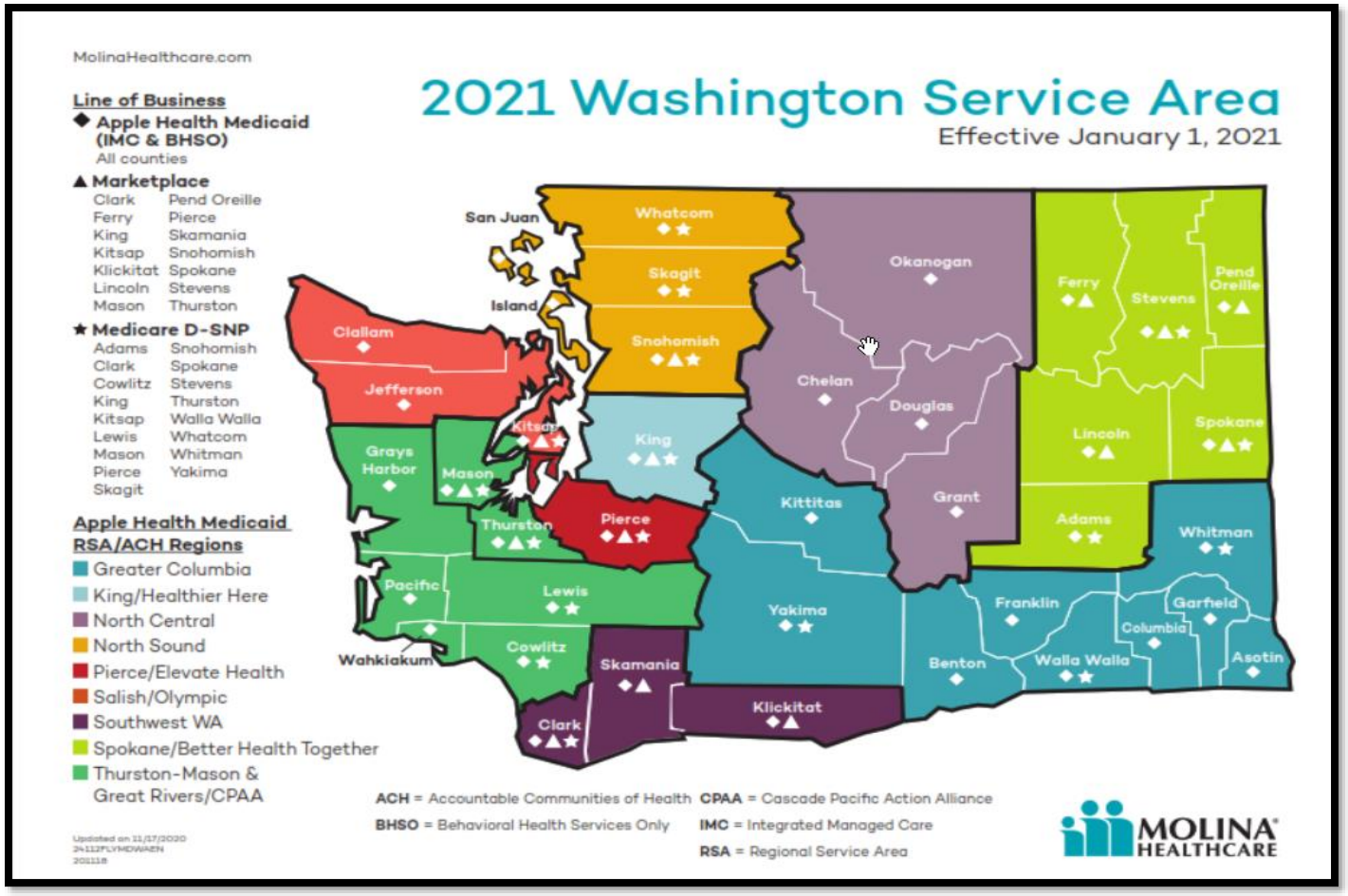
Caremark
Fax: (800) 869-7791
Online: www.caremark.com

Vision Service Plan (VSP®)

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

VSP®
Phone: (800) 615-1883

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


MolinaHealthcare.com
2021 Washington Service Area
Effective January 1, 2021
Line of Business
◆ Apple Health Medicaid (IMC & BHSO)
All counties
▲ Marketplace
Clark Pend Oreille
Ferry Pierce
King Skamania
Kitsap Snohomish
Klickitat Spokane
Lincoln Stevens
Mason Thurston
★ Medicare D-SNP
Adams Snohomish
Clark Spokane
Cowlitz Stevens
King Thurston
Kitsap Walla Walla
Lewis Whatcom
Mason Whitman
Pierce Yakima
Skagit
Apple Health Medicaid RSA/ACH Regions
Greater Columbia
King/Healthier Here
North Central
North Sound
Pierce/Elevate Health
Salish/Olympic
Southwest WA
Spokane/Better Health Together
Thurston-Mason & Great Rivers/CPAA
San Juan
Whatcom
Skagit
Island
Snohomish
Clallam
Jefferson
Okanogan
Chelan
Douglas
Ferry
Stevens
Pend Oreille
Lincoln
Spokane
Kitsap
King
Grays Harbor
Mason
Thurston
Pierce
Kittitas
Grant
Adams
Whitman
Pacific
Lewis
Yakima
Franklin
Garfield
Columbia
Asotin
Wahkiakum
Cowlitz
Skamania
Benton
Walla Walla
Klickitat
Clark
ACH = Accountable Communities of Health
BHSO = Behavioral Health Services Only
CPAA = Cascade Pacific Action Alliance
IMC = Integrated Managed Care
RSA = Regional Service Area
MOLINA HEALTHCARE

2. Provider Responsibilities

Non-discrimination of Healthcare Service Delivery
Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Medicaid website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

For more information about Non-discrimination of Healthcare Services Delivery, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

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

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

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

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA© (National Committee for Quality Assurance) required element. Invalid information can negatively impact Member access

to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) at least thirty (30) days in advance, 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 practice name, Tax ID and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (PCPs only)
- Any other information that may impact Member access to care

Please visit our Provider Online Directory at to validate and correct most of your information. A convenient Provider web form can be found on the POD and on the Provider Portal at https://provider.MolinaHealthcare.com. You can also notify your Provider Services Representative or via e-mail at MHWProviderContracting@MolinaHealthCare.com if your information needs to be updated or corrected.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Molina also may use a vendor to conduct routine outreach to validate data that impacts its Provider Directory or otherwise impacts its membership or ability to coordinate member care. Providers are required to provide timely responses to such communications.

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

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

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

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

Molina Electronic Solutions Requirements
Molina requires Providers to utilize electronic solutions and tools whenever possible.

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

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

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

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

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:
- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Provider Portal

Electronic Claims Submission Requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider including:

- Promotes HIPAA compliance.
- Helps to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminates mailing time and enabling Claims to reach Molina faster.

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal. See the Provider Portal Quick Reference Guide at https://provider.MolinaHealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38336, refer to our website www.MolinaHealthcare.com for additional information.

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

Provider Portal Claims submitting benefits include:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claims status
- Receive timely notification of a change in status for a particular Claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

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

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will

automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (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 processes.

Below is the link to register with Change Healthcare ProviderNet to receive EFTs/ERAs. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

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

Provider Portal

Providers and third-party billers can use the no cost Provider Portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy to use tool offers the following features:

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - Create and manage Claim Templates
  - Create and submit a Claim Appeal with attached files
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
- View HEDIS® Scores and compare to national benchmarks
- View a roster of assigned Molina Members for PCP(s)
- Download forms and documents
- Send/receive secure messages to/from Molina

Balance Billing

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 that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for covered services is prohibited, other than for the members applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Molina prior to use.

Please contact your Provider Services Representative for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

For additional information please refer to the Eligibility, Enrollment, Disenrollment and Grace Period section of this Provider Manual.

Clinical Data Repository Participation Requirements

Per Molina's contract with the Health Care Authority section 7.2.10.2.6, the cost to the subcontractors to program EHR systems or connect to the Health Information Exchange (HIE) are the responsibility of the individual entities. This means Molina network providers must participate in the WA Link4 Health Clinical Data Repository (CDR) beginning no later than February 1, 2017, if your organization is already invested and using certified EHR technology. If your organization is receiving Medicaid or Medicare

EHR incentive payments, it has already been determined that your system meets certification requirements. For more information you can visit:

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

Healthcare Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, and Medical Necessity review determination procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information please refer to the Healthcare Services section of this of this Provider Manual.

In Office Laboratory Tests

Molina's policies allow only certain lab tests to be performed in a Provider'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 Provider's office is found on the Molina website at www.MolinaHealthcare.com.

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at https://appointment.questdiagnostics.com/patient/confirmation and https://www.labcorp.com/labs-and-appointments.

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

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

Referrals

A referral is necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals 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 Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina except in the case of Emergency Services.

For additional information please refer to the Healthcare Services section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a prior authorization.

Treatment Alternatives and Communication with Members

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

Continuity and Coordination of Provider Communication

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

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews as applicable

- Delivery of Patient Care Information

Additionally, Providers with value-based contracts (VBC) work closely with Quality department staff to help ensure they receive updated information and support in meeting contracted goals. For example, VBC's meet monthly with Quality staff to review data on progress towards goals and develop and implement collaborative strategies for meeting these goals.

For additional information please refer to the Quality section of this Provider Manual.

PCP Role in Screening, Identifying, Intervening and Referring Members for Mental Health and Substance Use Disorder Services

The managed care plan is responsible for low to moderate and intensive mental health (MH) and substance use disorder (SUD) services. For members enrolled in IMC refer members to one of the in-network providers located on the Molina provider online directory.

It is the primary care provider's (PCP) responsibility to routinely screen members to assess whether they have any MH or SUD symptoms. If the results of the assessment indicate mental health or substance use disorder symptoms, the PCP is responsible for referring the member to the appropriate mental health or substance use disorder services, taking into consideration the member's motivation and interest in obtaining care. In addition, it is the PCP's responsibility to support and encourage the member toward reduction in symptoms related to MH or SUD to improve health outcomes and to support recovery. It is anticipated that the member will be educated related to the benefits of treating these conditions as well as the risks if not treated. Information on whole person care, the principles of recovery and provider strategies to support recovery can be found at www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care as well as through the University of WA AIMS Center website: www.aims.uw.edu. Additional information pertaining to substance use disorder can be found at www.asam.org. Please contact us if you are interested in additional resources to support this work with our members.

Referral for Mental Health Services

Molina Healthcare covers lower intensity outpatient MH services for mild-to-moderate MH conditions including psychotherapy, psychological testing and medication management as well as higher intensity MH services (such as residential or inpatient treatment) for IMC members. Members may also self-refer for MH services. Please see the Molina provider online directory, or contact our Molina Member Services, for a list of participating mental health providers.

Wraparound with Intensive Services (WISe) Providers

WISe providers are required to follow the program, policies and procedures contained within the Department of Social and Health Services (DSHS) Wraparound with Intensive Services (WISe) Manual, which is available at: www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf. WISe providers must participate in all WISe-related quality activities including but not limited to conducting or participating in a review of WISe services using the WISe Quality Improvement Tool (QIRT) at least once annually.

WISe providers are required to send Molina a notification of any adverse benefit determination (ABD) indicated in the WISe manual within 24 hours of the ABD determination. The WISe Notification form can be found under "Other" at www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx.

Referral for Substance Use Disorder

Molina Healthcare covers SUD treatment services including outpatient services, case management, opiate substitution treatment and inpatient/residential treatment. Members may also self-refer for SUD treatment services. Please see the Molina provider online directory, or contact our Molina Member Services, for a list of participating SUD providers.

Compliance

Providers must comply with all State and Federal Laws and regulations including chapter 42.56 RCW, 42 C.F.R. Part 2, related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. For additional information please refer to the Compliance section of this Provider Manual.

CFR 42 Part 2

Molina requires Providers comply with CFR 42 Part 2 which relates to the privacy of all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the

Provider will participate by providing medical records or statements 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.

For additional information please refer to the Complaints, Grievance and Appeals Process section of this Provider Manual.

Participation in Credentialing

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

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

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

Delegation

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

3. Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages 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 https://www.molinahealthcare.com/providers/wa/medicaid/resource/Pages/cme.aspx, from your local Provider Services representative and by calling Molina Provider Services at (855) 322-4082.

Nondiscrimination of Health Care Service Delivery

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

Additionally, participating Providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's

medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

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

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

Members can mail their complaint to Molina at:
Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, OCR. Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html. The form can be mailed to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you or a Molina Member needs help, call (800) 368-1019; TTY (800) 537-7697

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information:

https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Cultural Competency

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

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Molina conducts Provider training

during Provider orientation, with annual reinforcement training offered through Provider Services and/or online/web-based training modules.

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

1. Provider written communications and resource materials
2. On-site cultural competency training
3. Online cultural competency Provider training modules
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

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

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (e.g., braille, audio, large print), 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 Appeal and Grievance forms, are also available in threshold languages on the Molina Member website.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership
    - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- 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 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services

Molina 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 Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

Documentation

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

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

Members Who Are Deaf or Hard of Hearing

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

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

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

Nurse Advice Line

Molina provides Nurse Advice Services for Members 24 hours per day, 7 days per week. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call Molina's Nurse Advice Line directly: English line (888) 275-8750, Spanish line (866) 648-3537, or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the Handbook via the following link:

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

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

Below are the Member Rights and Responsibilities:

Molina Member Rights & Responsibilities Statement

As an enrollee, you have a right to:

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

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

You have the responsibility to:

As an enrollee, you agree to:

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

Special Provisions for American Indians and Alaska Natives

If an American Indian/Alaska Native (AI/AN) Enrollee indicates that he or she wishes to have an Indian Health Coverage Programs (IHCP) as his or her PCP, Molina must treat the IHCP as an in-network PCP for the Enrollee regardless of whether the IHCP has entered into a subcontract with Molina.

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

In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Molina is required to allow AI/ANs free access to and make payments for any

participating and nonparticipating IHCPs for contracted services provided to AI/AN Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.

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

Second Opinions

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

Women's Healthcare Services

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

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

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

Hospitals are required to notify Molina within 24 hours, or the first business day, of any inpatient admissions (including deliveries) for hospital services to be covered. Prior

authorization is still required for inpatient or outpatient surgeries. Please see Section 6, Medical Management for specific details.

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

Family Planning Services

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

Enrollee Self Determination

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

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

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

- **Physician Orders for Life Sustaining Treatment (POLST)** - The POLST form represents a way of summarizing wishes of an individual regarding life-sustaining

treatment. The form is intended for any individual with a serious illness. It accomplishes two major purposes:
    - It is portable from one care setting to another and it translates wishes of an individual into actual physician orders. An attending physician, ARNP or PA-C must sign the form and assume full responsibility for its accuracy.
- **Five Wishes-** Five Wishes is an easy-to-use legal advance directive document written in everyday language. It helps all adults, regardless of age or health, to consider and document how they want to be cared for at the end of life. https://fivewishes.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2

Mental Health Advance Directive
A mental health advance directive is a legal written document that describes what an individual wants to happen if their mental health problems become so severe that they need help from others. This might be when their judgment is impaired and/or they are unable to communicate effectively.

More information including a downloadable form can be found at www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-advance-directives.

Providers are encouraged to send any advance directive or POA documents to Molina Healthcare via email to ServiceFulfillment@MolinaHealthCare.Com.

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

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

5. Eligibility, Enrollment, Disenrollment

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

Molina Members are enrolled in a managed care health plan after the Health Care Authority (HCA) determines a Member is eligible for services through Apple Health Medicaid. Members may enroll with Molina if they reside within Molina's Service Area (www.molinahealthcare.com/providers/wa/medicaid/contacts/Pages/service_area.aspx . To initially enroll with Medicaid, an IMC or BHSO Member, his/her representative or responsible parent/guardian must apply online at www.wahealthplanfinder.org or call the Customer Support Center at (855)WAFINDER (855-923-4633) or (855) 627-9604 (TTY) where they can choose Molina as their health plan. Once a Member is eligible for Medicaid, he/she may change their health plan up to once per month. Member can change his/her plan at www.waproviderone.org.

For Apple Health Classic Medicaid coverage (adults over 65, blind or disabled, and/or needing long-term services and supports) apply online through Washington Connection at www.washingtonconnection.org or call (877) 501-2233.

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

IMC

- Members receiving Medicaid under the Social Security Act (SSA) provisions for coverage of families receiving Apple Health (AH) Family
- Members who are not eligible for cash assistance but remain eligible for Medicaid
- Members receiving Medicaid under the provisions of the ACA effective January 1, 2014 (Apple Health Medicaid Expansion)
- Children from birth through 18 years of age eligible for Medicaid under expanded pediatric coverage provisions of the SSA ("H" Children)
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the SSA ("S" Women)
- Children eligible for the Children's Health Insurance Program (CHIP).
- Categorically Needy-Blind and Disabled children and adults who are not eligible for Medicare
- Members who are eligible for Breast and Cervical Cancer Treatment, Categorically Needy Program
- Members who are eligible Categorically Needy Program, Long Term Care.

BHSO

- Dual eligible (Medicare-Medicaid)
- Apple Health foster children, foster alumni and adoption support in Fee-for-Service (FFS) physical health. (NOTE: These clients are managed only by Coordinated Care)
- Members who are eligible for the Medically Needy (spenddown) program
- Non-citizen pregnant women
- Members who are eligible for Institution for Mental Disease (IMD) and other Medicaid eligible long term or residential care

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

Effective Date of Enrollment

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

HCA notifies eligible Members of their rights and responsibilities and sends them a booklet at the time of initial eligibility determination. HCA sends Molina a daily list of assigned Members. Molina sends each new Member a Molina Member ID card and welcome kit within 15 days of initial enrollment with Molina. The letter includes important information for the new Member such as how to access their online handbook and how to contact Molina.

Inpatient at Time of Enrollment

Regardless of what Medicaid program or health plan the Member is enrolled in at discharge (Medicaid Fee-for-Service (FFS) or a managed care plan), the program or plan the Member is enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is discharged to home or a community residential setting. This includes behavioral health residential treatment facilities or a lower level of care, eligibility to receive Medicaid services ends, or the Member no longer meets rehabilitative or skilled criteria applicable to the skilled nursing facility setting.

For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization is responsible for payment of all the newborn's covered inpatient facility and professional services from date of birth until the date the newborn is discharged from an acute care hospital, unless their mother is on FFS Medicaid and newborn is determined eligible with managed care in the month of birth. If the newborn is not enrolled in managed care in the month of birth, facility costs, and professional services will be paid by FFS. A newborn whose mother is receiving services when the baby is born will be enrolled on an Apple Health plan according to Earlier Enrollment rules.

If their mother is not covered during the birth, and the newborn is found eligible and enrolled in managed care in the month of birth, the managed care plan will be responsible for all covered inpatient facility and professional services provided to the enrolled newborn starting from the date of birth or admission.

When a newborn is placed in foster care, the newborn will remain enrolled with the Apple Health plan for the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program (provided through Coordinated Care) effective the first of the month following placement of the newborn.

Enrollment Exemption: In some cases, a Member may request exemption from enrollment in a plan. Each request for exemption is reviewed by HCA pursuant to Washington Administration Code (WAC) 182-538-130.

Eligibility Verification

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

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

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

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

- Eligibility status
- Plan enrollment and plan name
- Medicare enrollment

- Availability of other insurance*
- Program restriction information

*Providers should use the Molina Healthcare WebPortal and not ProviderOne to verify the availability of other insurance as there is window of time this information may not be reflective in ProviderOne.

HCA updates the MEV vendor list as new vendors develop MEV services. For more information and a current list of HCA vendors visit HCA's website at https://www.hca.wa.gov/search/site/MEV%20vendors?section=%2A.

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

Eligibility Listing

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

PCP Capitation Groups

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

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

Identification Cards

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

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

Medical assistance program coverage is not transferable**.** If you suspect a Member has presented a ProviderOne (Services Card) belonging to someone else, you should request to see a photo ID or another form of identification. To report suspected Member fraud, call the HCA Medicaid Fraud Hotline at (360) 725-0934 or email WAHEligibilityFraud@hca.wa.gov. Do not accept a Services Card that appears to have been altered.

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

Members are reminded to carry both ID cards (Molina ID card and Services Card) with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services**.** Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

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

Voluntary Disenrollment

Members may request a different health plan via www.wahealthplanfinder.org, or may call or submit a written request to HCA to disenroll from managed care completely. Members whose enrollment is terminated will be prospectively disenrolled. HCA notifies Molina of all terminations. Neither the Provider nor Molina may request voluntary disenrollment on behalf of a Member.

Involuntary Disenrollment

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

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

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

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

Supplemental Security Income (SSI)

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

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

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

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

Molina engages with vendors Human Arc and Pacific Disability Resources (PDR) who reach out to Members that are identified as potentially SSI eligible individuals. The vendors assist the Member with completing the needed paperwork and tracking progress of the SSI application.

Maternity and Newborn Coverage

Obstetrical (OB) care is covered for all IMC members. An IMC newborn is automatically covered through the end of the month in which the 21st day of life falls. Continued coverage is contingent upon the mother reporting the newborn through the www.wahealthplanfinder.org portal or by calling (855) 923-4633. If eligible, the newborn will receive a Services Card. If the baby is not reported, medical coverage ends at the end of the month in which the 21st day of life falls, unless the baby is in the hospital in which case coverage ends at discharge. If the mother changes health plans within the initial three months of life, the newborn's coverage will follow the mother's coverage.

PCP Assignment

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

Molina will pay for services provided to a Member by any PCP that participates with Molina or one of the capitated medical groups/IPAs, regardless if the Member is currently assigned to that PCP.

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

PCP Change

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

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

Newborn PCP Assignment

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

Financial Responsibility and Medical Management Authority

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

PCP Dismissal

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

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

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

If a PCP wants to dismiss a member for any other reason, please contact your Provider Services representative.

PCP Panel Closure – "New Members"

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

- Family Members of existing Members will continue to be assigned;
- Members who were previously assigned to the PCP prior to a loss of eligibility will continue to be "reconnected" to the PCP.
- Members who a PCP has provided services two or more times in a 12-month period. The system automatically re-assigns the member based on claims data.

To request the change in panel status (closed or open), the provider must fill out the Provider Change Form and email it to MHWProviderInfo@MolinaHealthCare.Com The form must include the reason and the effective date of the status change.

PCP Panel Closure – "New & Previously Assigned Members"

In the event a PCP determines they are unable to serve not only New Members, but also Members who have been previously assigned, the PCP must close his or her panel by providing immediately completing the Provider Change Form and emailing it to MHWProviderInfo@MolinaHealthCare.Com

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

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

The current PCP must provide emergency care to the Member for thirty (30) days during this transition period.

6. Benefits and Covered Services

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

- Apple Health IMC with Premium (IMC-PREM)
- IMC Family/Pregnancy Medical (IMC-AH)
- IMC Adult (IMC-AHA)
- IMC (IMC-AHBD)
- Behavioral Health Services Only (BHSO)

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

In addition to receiving health care services from providers who contract with Molina Members may self-refer and receive certain benefits through local health departments, school-based health centers, family planning clinics or Indian Health Care Providers (IHCP) for the following:

- Family planning services and supplies
- Immunizations
- Tuberculosis (TB) screening and follow-up care
- Sexually Transmitted Disease (STD) screening and treatment services
- HIV or AIDS testing
- Behavioral health services
    - Assessment and intake
- Women's health services
- Crisis response services
    - Crisis intervention
    - Crisis respite
    - Investigation and detention services
    - Evaluation and treatment services

Washington Apple Health

Washington Apple Health is the name used in Washington State for Medicaid, the Children's Health Insurance Program (CHIP), and the state-only funded health care programs and includes Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO). It is a prepaid, comprehensive system of medical and behavioral health care delivery which includes preventive, primary, specialty and ancillary health services. HCA contracts with a number of health plans to provide health care to eligible Client groups.

IMC includes Clients eligible for:

- Temporary Assistance for Needy Families (TANF)
- Pregnant women with family incomes up to 193% of the federal poverty level (FPL)
- Children with family incomes up to 312% of FPL not eligible for other Medicaid programs
- Blind and Disabled (SSI) children and adults not eligible for Medicare
- Adult Medical or Medicaid Expansion up to 133% of FPL
- Breast and Cervical Cancer Treatment, Categorically Needy Program
- Categorically Needy Program, Long Term Care

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

Behavioral Health Services Only (BHSO)

BHSO is for specialty behavioral health (mental health and substance use disorder) services only. BHSO Members receive their physical health care and all medication through their primary medical coverage such as; Medicare (traditional or Part C), private health insurance or the Medicaid fee-for-service while they meet spenddown requirements before they are eligible for Apple Health benefits.

Well Child Visits and EPSDT Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of comprehensive screening, diagnostic and treatment services for children under the age of 21 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 AAP and Bright Futures. See EPDST program billing guide at https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

The screening services include:

- Complete health and developmental history (including assessment of both physical and mental health developmental
- Immunizations in accordance with the most current Washington state 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 Health Care Authority targeted State standards. 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 (800) 869-7165.

Vaccines for Children

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

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

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

Obtaining Access to Certain Covered Services

Telehealth and Telemedicine Services

Molina Members may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a Participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.

For additional Telemedicine benefit information please consult the HCA billing guide at: https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-serv-bg-10012020.pdf

Upon at least ten days prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

For additional information on Telehealth and Telemedicine Claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

Emergency and Urgent Care Services

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

24-Hour Nurse Advice Line

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

English Phone: (888) 275-8750
Spanish Phone: (866) 648-3537
TTY/TDD: 711

Molina is committed to helping our Members:
- Prudently use the services of your office
- Understand how to handle routine health problems at home
- Avoid making non-emergent visits to the emergency room (ER)

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

Emergency Mental Health or Substance Abuse Services

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

- Danger to self or others.
- 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 emergency room.
- Call the number on ID card.
- Call Member's PCP and follow-up within 24 to 48 hours.

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

Washington Recovery Help Line

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

Health Education/Disease Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators along with access to educational materials. You can refer Members who may

benefit from the additional education and support Molina offers. Members can request to be enrolled or disenrolled in these programs at any time. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Heart Failure
- 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 these programs, please call (866) 472-9483 (TTY/TDD at 711 Relay).

For additional information, please refer to the Healthcare Services section of this Provider Manual.

7. Healthcare Services

Introduction

Healthcare Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated 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. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)

- Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level 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 as well as integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes in the Member's condition 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 and CM processes
- Ensuring that UM decision making tools are appropriately applied in determining medical necessity decision

Key Functions of UM Program

The table below outlines the key functions of the Utilization Management (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 Provider input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensure authorized care correlates to Member's medical necessity need(s) & benefit plan	Post service/post claim audits	Monitor for possible over- or under-utilization of clinical resources
Verifying current Physician/hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA©, State and health plan UM standards

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

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

UM Decisions

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

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny payment of request (adverse determination);
- Discontinuation of a payment for a service;
- Payment for temporarily out-of-the-area renal dialysis services; and,
- Payment for Emergency Services, post stabilization care or urgently needed services.

Molina follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Molina covers all services and items required by State and Federal regulations.

Board certified licensed Providers from appropriate specialty areas are 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 National Committee for Quality Assurance (NCQA) standards.

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, 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.

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

Medical Necessity

"**Medically Necessary**" or "**Medical Necessity**" means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the Enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity, or malfunction. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the Enrollee requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).
This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

1. In accordance with generally accepted standards of medical practice;

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

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

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence-based guidelines, third party guidelines (e.g. InterQual ®, MCG, American Society of Addiction Medicine), CMS (Centers for Medicare & Medicaid Services) guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review
The Molina review process begins with administrative review followed by clinical review if appropriate. The administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage.

- Verifying Member eligibility.
- Requested service is a covered benefit.
- Requested service is within the Provider's scope of practice.
- The requested covered service is directed to the most appropriate contracted specialist, facility or vendor.

The Clinical review includes medical necessity and level of care.

- Requested service is not experimental or investigation in nature.
- Servicing 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.
- Medical necessity criteria (according to accepted, nationally recognized resources) is met.
- 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.
- The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

All UM requests that may lead to a denial are reviewed by a healthcare professional at Molina (medical director, pharmacy director, or appropriately licensed health professional).

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

Clinical Information

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

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at www.molinahealthcare.com/providers/wa/medicaid/home.aspx. Providers are encouraged to utilize Molina's self service provider portal. Information regarding Pre-Authorizations and Admission Notifications can be found on the One Health Port Pre-Service Directory, available at: www.onehealthport.com/psd-home. Providers may submit and check the status of a service, access clinical criteria and a list of required prior -authorization documentation or request authorizations.

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 Portal. Contact telephone numbers, fax numbers and addresses are noted in the Addresses and Phone Numbers section of this Provider Manual.

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

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.

- Clinical information sufficient to document the medical necessity of the requested service is required including:

    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).
    - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and member eligibility at the time of service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. The definition of expedited/urgent is when the passage of time could seriously jeopardize the life or health of the enrollee, the health or safety of the member or others, due to the member's psychological state, or in the opinion of the provider with knowledge of the enrollee's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the enrollee's ability to attain, maintain or regain maximum function or subject the enrollee to sever pain that cannot be adequately managed without the care or treatment that is the subject of the request. Supporting documentation is required to justify the expedited request.

For expedited request for authorization, a determination is made as promptly as the Member's health requires and no later than 72) hours after we receive the initial request for service (48 hours if all necessary information is received with the request) 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 provides notification within 5 calendar days of the receipt of necessary information but are allowed up to 14 calendar days, if additional information is required and requested by the Contractor within 5 calendar days of the original receipt of the request for services.

The Peer-to-Peer and Reconsideration Process
In order to avoid the appeal process, the requesting provider has an option to request a peer-peer consult with a medical director. The request must be made within the following timelines from receipt of the adverse benefit determination (denial) notification (verbal or fax):

- Inpatient: 10 business days or within 5 business days of discharge
- Pre-service: 10 business days
- Any time before a decision is made

To schedule a Peer-to-Peer, call (425) 398-2603 or (800) 869-7175 ext. 142603.

Upon approval, the requestor and member will receive the approval information including the authorization number via phone, electronic or mail. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone when possible or by fax with confirmation of receipt if telephonic communication fails.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina, Molina may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the www.MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix
- Prior Authorization Guide

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

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.

- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.
- Find criteria used by Molina in Authorization determinations

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

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

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

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

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services Department at: (855) 322-4082 or Kaiser Foundation Health Plan of the Northwest: (800) 813-2000 for Kaiser patients. 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 Washington
Attn: Healthcare Services Dept.
PO Box 4004
Bothell, WA 98041-4004

Genetic Lab Testing and Prior Authorization

Currently Molina requires prior authorization for genetic testing. Effective September 1, 2018 Molina Healthcare of Washington will require that Quest or Lab Corp be used for these lab services. If other labs are used these services will be redirected to Quest or Lab Corp. If the lab sample is in route to a lab other than Quest or Lab Corp, before the prior authorization is requested, the lab sample will need to be redirected before

authorized. If an exception is required, the ordering physician must send in a request along with a letter explaining why an exception should be considered. The request will be reviewed by a Medical Director.

Emergency Services

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

Emergency Medical Condition or Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) 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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency Care for Behavioral Health Condition means services provided for an individual, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability.

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.

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

Molina accomplishes this service by providing a 24-hour Nurse Advise line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina contracts with vendors that provide 24-hour Emergency Services for ambulance and hospitals. An out of network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment.

Molina covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the

treating hospital requests authorization until the time the patient is discharged, or a contracting medical provider agrees to other arrangements.

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

Members over-utilizing the emergency department will be contacted by Molina Care Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

Care 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.

Certified Public Expenditure (CPE) Hospitals

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

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all Medical/Surgical (M/S) and Mental Health (MH)/Substance Use Disorder (SUD) elective/scheduled inpatient admissions and procedures to any facility. Facilities are required to also notify Molina within 24 hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all M/S, MH, & SUD emergent inpatient admissions (unplanned or court ordered) within 24 hours of admission or by the following business

day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at time of Termination of Coverage

See “Inpatient at time of Enrollment” under Eligibility, Enrollment, Disenrollment section.

Inpatient/Concurrent Review

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

Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that 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. Upon discharge the Provider must provide Molina with a copy of Member’s discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina’s UM staff follow Centers for Medicare & Medicaid Services (CMS) guidelines to determine if the collected 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 (refer to the Medical Necessity Standards section of this manual).

The Peer-to-Peer and Reconsideration Process

In order to avoid the appeal process, the requesting provider has an option to request a peer-peer consult with a medical director. The request must be made within the following timelines from receipt of the adverse benefit determination (denial) notification (verbal or fax):

- Inpatient: 10 business days or within 5 business days of discharge
- Pre-service: 10 business days
- Any time before a decision is made

To schedule a Peer-to-Peer, call (425) 398-2603 or (800) 869-7175 ext. 142603

Discharge Planning

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.

UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Molina conducts retrospective (post claims) readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. If it is determined that the subsequent admission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions. Readmission to the same acute facility within 14 days of the initial or index admission will be subject to clinical reviews if the readmission is determined to be related to the previous admission. (WAC 182-550-2950)

A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital;
- Issues with transition or coordination of care from the initial admission;
- For an acute medical complication plausibly related to care that occurred during the initial admission.

Readmissions that are excluded from consideration as preventable readmissions include:

- Readmission for reasons unrelated to conditions or care from index or initial admission

- Repetitive treatments such as cancer chemotherapy or other required treatments for cancer, transfusions for chronic anemia, burn therapy, dialysis or other planned treatments for renal failure
- Planned therapeutic or procedural admission following diagnostic admissions when the therapeutic treatment clinically could not occur during the same case
- Same day planned admission to a different hospital unit for continuing care and can include mental health/substance use disorder transfers, and rehabilitation transfers which may be technically coded as discharge/admission for billing reasons.
- Required treatments for cancer including treatment related toxicities, or care for advanced stage cancer
- End of life and hospice care
- Patients who left Against Medical Advice (AMA) from index or initial admission.
- Readmission due to patient non-adherence to the discharge plan, despite appropriate discharge planning. This also includes cases where the recommended discharge plan was refused by the patient, and a less appropriate alternative plan was made to accommodate patient preferences; this must be clearly documented in the record.
- Obstetrical readmission for birth after an antepartum admission
- Admissions with a primary diagnosis of mental health and substance use disorder issue
- Transplant readmissions within 180 days of transplantation
- Neonatal readmissions
- Readmissions when the index admission occurred in a different hospital system.

Administrative Days

Hospitals requesting authorization of administrative days must submit a separate authorization request from the inpatient hospital stay. All hospitals are intitled to bill administrative days including for Mental Health, LTAC, Physical Medicine and Rehabilitation. Administrative days are intended for Mental Health services in a community hospital only and not available for service provided in an Evaluation/ Treatment Center.

Hospital facilities have up to 10 business days to request an administrative day rate from the date of the expiration of the inpatient authorization, the notice of adverse benefit determination for continued stay authorization, or the exhaustion of the appeal process, whichever is later.

Molina requires the following information be included in the request for authorization:
- Current clinical data
- Submission of documented discharge/placement efforts
- Documentation of phone call and fax responses regarding placement to include specific information of contacted providers
- Documentation of specific rationale for declines related to placement
- Plan of care including specific needs and long-term goals

If the Members condition is such that custodial care is appropriate, the Provider/Facility will be directed to Home Community Services (HCS) for Long Term Care (LTC) for future placement needs. If the Members diagnosis includes Chemical Dependency issues the Provider will be asked to refer the Member for possible Substance Use Disorder (SUD) treatment.

Authorization process for Mental Health follows the HCA Provider Billing Guide for Mental Health.

Acute administrative days will require Prior Authorization (Admin Day template/rev code 0191/0169) and may be authorized subject to the following:
- The member has a legal status of “voluntary.”
- The member no longer meets Medical Necessity criteria.
- The member no longer meets Intensity of Service criteria.
- Less restrictive alternatives are not available, posing a barrier to safe discharge.
- The hospital and Molina Healthcare mutually agree to the appropriateness of the administrative day.

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

Post Service Review

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 Member or there was a Molina error, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence-based criteria sets.

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

Affirmative Statement about Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Molina requires that all utilization-related decisions regarding member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care. And, Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

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

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (800) 869-7175 during normal business hours, Monday through Friday (except for Holidays) from 7:30

a.m. to 5:00 p.m. All staff Members identify themselves by providing their first name, job title, and organization.

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

After business hours, Providers can also utilize fax and the Provider Portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (888) 275-8750. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters.

Out-of-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

Coordination of Care and Services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral such as; self-referral, provider referral, etc. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end.

Molina staff provide an integrated approach to care needs by assisting Members, with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

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

Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to 90 days or longer if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.

High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (800) 869-7175.

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

Reporting of Suspected Abuse and/or Neglect

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

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

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

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

Child Abuse

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

Hotline: 1-866-ENDHARM (866-363-4276)
TTY Callers:(800) 624-6186

Adult Abuse

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

Molina'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 State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

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

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 care manager provides the PCP with, the member's ICP, Interdisciplinary Care Team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager Responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions

from Member's ICT, as applicable. ICP interventions include the appropriate information to address physical, behavioral and psychosocial 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 care manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the Member to determine if the Members' needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Members' ICT, as members needs warrant.
- Serves as a coordinator and resource to the Member, their representative and ICT participants throughout the implementation of the ICT and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the Integrated Care Management (ICM) program.

Smoking Cessation

Molina Healthcare offers two options for Smoking Cessation:

1. Our Molina Health Management team have Health Educators who support our Members through the first 3-6 months of the quit process. The frequency of outreach is agreed upon between the Member and the health educator and is usually most frequent during the first 60 days. The number of Member-initiated calls is unlimited. The targeted population is adults ages 18 years of age and older. Members can self-refer to the program or be referred by their provider, case management, or other internal Molina departments.

2. Molina Healthcare of Washington also contracts with Optum Health to offer the Quit-4-Life smoking cessation program to Medicaid Apple Health members 18 years of age and older. Members who request smoking cessation services are eligible to receive four scheduled coaching calls and unlimited support. Smoking cessation counselors provide behavioral cognitive coaching and decision support regarding method to use to help stop smoking. Members also receive a Quick Guide – a workbook tool to help them quit - and have full access to all of the

programs Alere promotes. For example, Quit for Life Smoke-out; 4 Essential Practices – Quit for Life; etc. Members can call Quit-4-Life (1-866-784-8454) to enroll.

Member Newsletters

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

Member Health Education Materials

Members can access our easy-to-read materials 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 (HM) Programs are designed for Molina Members with a confirmed diagnosis.

Identified members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which include the following:

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant Centers for Medicare & Medicaid Services (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;
- External referrals from Provider(s), caregivers or community-based organizations
- Internal referrals from Nurse Advice Line, Medication Management or Utilization Management
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider Participation

Contracted Providers are notified as appropriate, when the Member is 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
- Preventive Health Guidelines

Additional information on Health Management Programs is available from your local Molina Healthcare Services Department toll free at (800) 869-7175.

Case Management (CM)

Molina provides a comprehensive Integrated Care Management (ICM) program to all Members who meet the criteria for services. The ICM program focuses coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina care managers may be licensed professionals and are educated, trained and experienced in the Molina ICM program. The ICM 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 ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina care manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing physical/behavioral health care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP ICM program enrollment, as well as facilitating and assisting with the development of Members ICP.

Referral to Care Management: Members with high-risk physical, behavioral conditions and/or other care needs may be referred by their PCP or specialty care Provider to the

CM program. The care manager works collaboratively with the Member and all participants of the Interdisciplinary Care Team (ICT) when warranted, including the PCP and specialty Providers, such as, discharge planners, ancillary Providers, the local Health Department and other community-based resources when identified. The referral source should be prepared to provide 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 ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, CHF, etc.)
- Preterm births
- High-technology home care requiring more than 2 weeks of treatment
- Member accessing Emergency Department services inappropriately
- Children with Special Health Care Needs
- Behavioral Health (Mental Health and Substance Use Disorder)

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

Transitions of Care

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

- Molina defines ToC to include all services required to ensure the coordination and continuity of care from one care setting to another as the member's health status changes. This includes members discharging from medical, psychiatric, and substance use disorder inpatient treatment facilities and others. Molina's ToC team will confirm and re-establish the patient's connection to their medical home/Primary Care Physician/Specialist and assist with the coordination of care as the patient moves from one care setting to another. The target populations for

Molina's ToC program are patients that are at a high risk of re- admission, based on medical literature and 30 years of experience serving the Medicaid population. Identified care settings that are supported in the ToC program include but are not limited to, the following:

- Hospital/Acute Care
- Inpatient Psychiatric facilities/centers
- Long Term Acute Care
- Skilled Nursing Facility
- Rehabilitation Facility
- Home

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

Molina members may be contacted by a ToC Coach via a face-to-face or telephonic visit while in the inpatient setting. The ToC Coach with the facility care team works to develop an individual care transition plan. Following discharge, the member may receive a follow-up phone call within 5-7 days after discharge, and a face-to-face visit in their place of residence within one week after discharge if needed. The ToC Coach will assess the members ability to make and attend all needed follow up appointments, complete medication reconciliation, nutrition management, patients understanding of illness and how to recognize worsening symptoms, when to call their Primary Care Physician, and develop a sick day plan, assess home safety, the Member's support network and community connections, and will assist the Member with obtaining immediate psychosocial needs such as food, transportation, clothing, social support, advocacy, and other community-based resources.

The ToC will continue to provide care coordination for up to 4 weeks, based on member needs and preferences. During each follow-up contact, primarily performed via telephone, the ToC Coach ensures that the goals of the ICP have been met and the member has successfully transitioned to a lower level of care. As the transitions of care process nears completion, Molina's ToC Coach will identify any ongoing needs that a Member may have and, if needed, coordinate a referral to the Molina Case Management program or Primary Care Physician who will work with the Member to address those needs going forward.

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

- Assess and stratify members into levels of risk to prevent re-admission
- Create an individual care plan to mitigate readmission to include:
    - Health education to support discharge care needs for example: Medication management, ensure follow-up appointments are attended, self-management of conditions, when and how to seek medical care. Care planning is to include caregivers as needed
    - Written discharge plan must be given to Member/caregiver and treating providers
      based on Member needs and preferences to ensure timely access to follow up care post discharge and identify and re-engage Members who do not receive post discharge care.
    - Organize post discharge services, home care services, after-treatment services and therapies, etc.
    - Telephonic reinforcement of discharge plan and needed problem solving within 5-7 business days from time of discharge
    - Information on what to do if a problem arises following discharge
    - For patients at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition
    - For patients at high risk of re-hospitalization, ensure Primary Care Provider or Care Coordinator will visit patient residence or secondary facility such as skilled nursing facility or residential mental health facility within 7 calendar days post discharge as needed to support discharge instructions, assess environment safety, conduct medicine reconciliation, assess adequacy of support network and services, link to appropriate referrals.

Planning activity should include Members family and caregivers and support network in assessing needs.

Members engaged in Health Homes program will receive ToC services from Health Homes Care Coordinator and will follow the Health Homes Transitions of Care process.

To prevent duplication of services Molina will coordinate required elements with admitting facilities and assist in providing required elements that admitting facilities are unable to provide.

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

Health Home Services

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

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

Molina Healthcare of Washington is a qualified Health Home (AKA "lead entity") for geographic area 1 (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties); area 2 (Island, San Juan, Skagit, and Whatcom Counties); area 3 (King); area 4 (Pierce); area 5 (Clark, Klickitat, Skamania, Cowlitz and Wahkiakum); area 6 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman Counties) and area 7 (Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin). Molina is contracted with qualified lead entities in 3 other areas across the state to provide Health Home services. As a qualified lead entity, Molina is responsible for providing (or contracting for) the following six (6) specific care coordination services functions:

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

As a lead entity, Molina has created integrated provider networks in the above areas to ensure physical health, mental health, chemical dependency, long term services and social support needs can be met through an integrated collaborative approach.

Molina has contracted with various qualified Care Coordination Organizations (CCO) who will hire a team of care coordination staff responsible for delivery of face-to-face interactions with qualified Health Home enrollees. Molina is also functioning as a direct (CCO) to provide direct member interactions in limited areas.

The care coordination staff is a combined team of care coordinators and community health workers. The dedicated care coordination staff will provide individual enrollee

interactions aimed at delivery through 6 Health Home elements of care coordination (see previous description).

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

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

The clinical care coordinator will be responsible for informing and coordinating services with a Member's current medical team and other community support services. When your client is receiving Health Home services you will be notified by the care coordinator.

If you would like more information about Health Homes and Molina's Health Home program, information can be found at www.MolinaHealthcare.com/providers/wa/medicaid/resource/Pages/healthhomes.aspx

Cancellation of Prior Authorized Services

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

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

Second Medical/Surgical Opinion

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

- Molina Members may request a second opinion about the care they are receiving at any time.
- The member may request the Second Opinion through their assigned PCP or through Molina's Member Service Department.
- Second opinion consultations with participating practitioners, arranged by the member's PCP, do not require review or prior approval by Molina.

- A Member Services representative can assist the Member in coordinating the second opinion request with the Member's PCP, specialist and/or medical group/IPA.
- An approval to a non-participating Provider will be facilitated by Molina or the medical group/IPA if the requested specialty care Provider or service is not available within the Molina network.
- The appointment for the second opinion will occur within thirty (30) days of the request. The Member may request to postpone the second opinion to a date later than 30 days.
- The Medical Director may request a second opinion at any time on any case deemed to require specialty Provider advisor review.

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

Wrong Site Surgery

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

8. Quality

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality Department toll free at (800) 869-7175, via email at MHW_QI_Department@Molinahealthcare.com or fax at (800) 461-3234. The address for mail requests is:

Molina Healthcare of Washington, Inc.
Quality Department
25140 30th Dr. SE Ste. 400
Bothell, WA 98021

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

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

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

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

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina 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 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) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

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

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

Molina is not required to pay for inpatient care related to “never events.”

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member’s record. PCPs should maintain the following components:

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

Medical Record Keeping Practices

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

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit and archived records are available within twenty-four (24) hours.
- If hardcopy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.

- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

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

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact;
- Legible signatures and credentials of Provider and other staff members within a paper chart;
- All Providers who participate in the Member's care;
- Information about services delivered by these Providers;
- A problem list that describes the Member's medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions (or notation that none are known);
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- Treatment plans that are consistent with diagnosis;
- A working diagnosis that is recorded with the clinical findings;
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests that are ordered as appropriate by the practitioner;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date immunization records and documentation of appropriate history;
- All staff and Provider notes are signed physically or electronically with either name or initials;
- All entries are dated;

- All abnormal lab/imaging results show explicit follow up plan(s);
- All ancillary services reports;
- Documentation of all emergency care provided in any setting;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth; and
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release medial information for facilitation of medical care.

Retrieval

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

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.

- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality department toll free at (800) 869-7165. See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (adult and pediatric) and participating specialists (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 90% availability for Emergency Services and 90% or greater for all other services. The PCP or his/her designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

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

Medical Appointment Types	Standard
Routine, asymptomatic	Within 30 calendar days
Routine, symptomatic	Within 10 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 30 calendar days
Specialty Care (High Impact)	Within 30 calendar days
Urgent Specialty Care	Within 24 hours
Care Transitions – PCP Visit	Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program
Care Transitions – Home Care	Transitional health care by a home

	care nurse or home care mental health professional or other behavioral health professional within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health, if ordered by the member's PCP or as part of the discharge plan
Behavioral Health Appointment Types	**Standard**
Life Threatening Emergency	Immediately
Non-Life Threatening Emergency	Within 6 hours
Urgent Care	Within 24 hours
Routine Care	Within 10 calendar days
Follow-up Routine Care (Prescriber)	Within 30 calendar days
Follow-up Routine Care (Non-Prescriber)	Within 20 calendar days

Additional information on appointment access standards is available from your local Molina Quality department.

Office Wait Time

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

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, 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. Voicemail alone after-hours is not acceptable.

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 Provider Services department toll free at (855) 322-4082 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 interpretation
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina 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 your local Molina Quality department toll free at (800) 869-7165.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

Provider Network adherence to access standards is monitored via one or more of the following mechanisms:

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

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

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member complaints and appeals/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit.
This includes an assessment of:

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space

Physical Accessibility

Molina evaluates office sites, as applicable, 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 patients with physical disabilities.

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is 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 Provider.
- 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 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 injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directive's 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. There are 3 types of Advance Directives:

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

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

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

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 website. If a Member is incapacitated at the time of enrollment, Molina 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 or are directed to the CaringInfo website at www.caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

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

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

Molina will notify the Provider of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

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

EPSDT Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services to Enrollees under twenty-one (21) years of age 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(R) of the Social Security Act. Molina's Quality 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.

Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all Enrollees under 21 years of age are timely according to required preventive health guidelines. All Enrollees under 21 years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the by the preventive health guidelines located on the Molina Provider Website (www.MolinaHealthcare.com) and referenced in the Benefits and Covered Services section of this Provider Manual.

Well Child/Adolescent Visits

Visits consist of age-appropriate components, that include but are not limited to:

- Comprehensive health and developmental history.
- Nutritional assessment.
- Height and weight and growth charting.
- Comprehensive unclothed physical examination.
- Appropriate immunizations according to the Advisory Committee on Immunization Practices.

- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors.
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool.
- Vision and hearing tests.
- Dental assessment and services.
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention.

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

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Within 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 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 Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. The Quality Improvement Program 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 and Care Management

The Molina Health Management and Care Management Programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please see the Health Management and Care Management headings in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. CPGs are reviewed at least annually, and more frequently as needed, when clinical evidence changes and approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Bipolar Disorder
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Detoxification and Substance Abuse Treatment
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Opioid Management
- Perinatal/Prenatal/Postnatal Care
- Sickle Cell Disease

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, electronic Provider Bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from the local Molina Quality department.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures /American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Adult Preventive Services Recommendations

- Pediatric Preventive Services Recommendations
- Immunization schedules for children and adolescents
- Immunization schedules for adults

All Preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at www.molinahealthcare.com/providers/wa/medicaid/home.aspx and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

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

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

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

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

Molina's most recent results can be obtained from your local Molina Quality department or by visiting our website at www.molinahealthcare.com.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the National Committee for Quality Assurance (NCQA) HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the

spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

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

Behavioral Health Survey

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy

authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

What Can Providers Do?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, Provider Portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® Star Ratings measures, contact your local Molina Quality department

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

Clinical Incident Reporting

I. What is a Critical Incident?

- Critical Incidents are traumatic. When one of our members experiences a Critical Incident (CI), Molina is responsible for following up to ensure they have the care they need.

- CIs are reported to the Healthcare Authority (HCA) by Molina through semi-annual reporting as well as 24-hour notification to the HCA Incident Reporting System.
- In order to provide follow-up, it is important that our external provider network reports CIs to Molina as soon as the incident has been identified.

II. Critical Incident Reporting Criteria

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

B. Violent acts allegedly committed by a member to include:

a. Homicide or attempted homicide
b. Arson
c. Assault resulting in serious bodily harm which has the potential to cause prolonged disability or death
d. Kidnapping
e. Sexual assault

C. Abuse, neglect or exploitation of a member; not to include child abuse (APS/CPS reporting)

NOTE: The Health Care Authority has recently announced that child abuse cases are no longer required to be reported to the Medicaid MCOs such as Molina through the Critical Incident process, but rather are reported directly to the Children's Administration/CPS as part of mandatory reporting requirements. The intent is to reduce the burden of reporting and eliminate duplicative reporting as much as possible. However, if the incident also falls under one of the additional critical incident reporting criteria outlined here, it must be reported through Molina's critical incident process.

If you have any questions, please contact us at CIreporting@MolinaHealthcare.com

D. Death that occurred within a contracted behavioral health facility (inpatient, psychiatric, behavioral health agencies), FQHC or by independent behavioral health provider.

E. Unauthorized leave from a behavioral health facility during an involuntary detention.

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

III. What a Critical Incident is NOT:

A. Threatening suicide or suicidal ideation (thinking about it)

B. Routine car accidents not resulting in a serious injury

C. Accidents-minor not resulting a serious injury

D. The unexpected death or serious injury of an enrollee

E. A credible threat to enrollee safety

F. Any allegation of financial exploitation of an enrollee

IV. How do I report a Critical Incident?

A. As soon as you are notified of the critical incident

a. Ensure member safety first, then report

b. Some critical incidents require notification to HCA w/in 1 business day of Molina notification, so it is important that you report to Molina as soon as possible

B. Molina's Critical Incident form can be found atwww.MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

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

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

9. Compliance

Fraud, Waste, and Abuse

Introduction

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

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

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

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

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

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

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

Deficit Reduction Act

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

. As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of Medicare or Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false Claims;
- How Providers will detect and prevent fraud, waste, and abuse; and.
- Whistleblower protection rights as whistleblowers.

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 Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government may 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 will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute (AKS) – The AKS is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

Stark Statute – The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a

corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: 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: means 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: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste, and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.

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

Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud Medicaid.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance department.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Claims are processed accurately and ensure that payments reflect the service performed as authorized.

Molina performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

Through implementation of Claims edits, Molina's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS) Federal guidelines, AMA and published specialty-specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit table, the Medicaid National Correct Coding Initiative (NCCI) files and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina may, at the request of a State program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

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

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

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

Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, State and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and 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 as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that Molina paid in error. The estimated proportion,

or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide Molina, or Molina's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

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

Molina 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 (CAP) to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste, and Abuse

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

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

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the remittance advice and claim information to:

Molina Healthcare of Washington, Inc.
PO Box 30717
Los Angeles, CA 90030-0717

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services.

AlertLine telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll free at (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's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

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

Remember to include the following information when reporting:
Nature of complaint.
The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Molina Member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the State at:

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

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

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:
42 C.F.R. Part 2 regulations
Health Information Technology for Economic and Clinical Health Act, ("HITECH Act")

Applicable Laws

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

1. Federal Laws and Regulations

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

2. State Medical Privacy Laws and Regulations.

Providers should be aware that HIPAA provides a floor for patient privacy, but that State Laws should be followed in certain situations, especially if the State

Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosure of PHI

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

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

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

    - Quality Improvement
    - Disease Management
    - Care Management and Care Coordination
    - Training Programs
    - Accreditation, Licensing, and Credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as Healthcare Effectiveness Data and Information Set (HEDIS®) and Quality Improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although

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

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

HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

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

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law.

Patient Rights

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

1. Notice of Privacy Practices

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

2. Requests for Restrictions on Uses and Disclosures of PHI

Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. Requests for Confidential Communications

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

4. Requests for Patient Access to PHI

Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI

of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. Request to Amend PHI

Patients have a right to request that the Provider amend information in their designated record set.

6. Request Accounting of PHI Disclosures

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

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity 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 strongly supports the use of electronic transactions to streamline health care administrative activities. Molina Providers are encouraged to submit Claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at www.molinahealthcare.com/providers/wa/medicaid/home.aspx for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

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

National Provider Identifier (NPI)

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues

- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

10. 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
- Behavioral Health Supplemental Transactions
- Evidence/Research Based Practices
- Rosters

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

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. Centers for Medicare & Medicaid

Services (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) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers:

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

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

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Provider Portal whenever possible 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 38336**.** For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

Required Elements

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification number (TIN).
- 10-digit National Provider Identifier (NPI).
- Rendering Provider name as applicable.
- Billing/Pay-to Provider name and billing address.

- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location information.
- Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

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.

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

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

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

Electronic Claims Submission

Molina strongly encourages participating Providers to submit Claims electronically, including secondary claims. Electronic Claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

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

Provider Portal

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

- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Provider 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 uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

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

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve 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

Participating Providers should submit claims electronically. If electronic claim submission is not possible, please submit paper claims to the following address:

Molina Healthcare of Washington
PO Box 22612

Long Beach, CA 90801

Please keep the following in mind when submitting paper claims:

- Paper claims should be submitted on original red colored CMS 1500 claims forms
- Paper claims must be printed, using black ink.

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

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina 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 or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOBs) and other required documents, by utilizing Molina's Provider Portal. Providers can also submit this information through EDI and Paper submissions. You may also submit COB claims via the clearing house by populating the appropriate segments with the primary payment information.

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

- Medicare is primary and the service being billed is a non-covered service by Medicare.
- The primary carrier has no available provider within a 25-mile radius of the members address. If claims are denied for this reason the provider may contact Provider Services to request the claim be processed for payment.
- The primary insurance only covers emergency services or offers limited benefits. Molina will contact the primary carrier to validate and update our systems to reflect Molina as the primary carrier.
- The member is American Indian/Alaskan Native (AI/AN).

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

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

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

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

Third Party Liability (TPL)

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

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services or what is outlined in your provider contract. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within 180 calendar days after final determination by the primary payer or what is outlined in your provider contract. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the

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

Molina utilizes a claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare and Medicaid Services (CMS), including:
    - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
    - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
    - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
    - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Updates within 60 days of update from CMS or state Medicaid agencies:

CMS and state Medicaid agencies issue periodic updates, additions, and revisions to their fee schedules, payment policies, payment rates, payment methodologies, regulations, and other provisions for services furnished under the various fee schedules. Molina implements these updates and revisions on a prospective basis within 60 days

of the update or revision from the agency. The update or revision will be applied upon implementation to all Claims received after the implementation.

Telehealth Claims and Billing

Provider must follow CMS guidelines as well as State-level requirements.

All Telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type. Use the Telehealth Place of Service (POS) Code 02, which certifies that the service meets the Telehealth requirements. By coding and billing a place of service 02 with a covered Telehealth procedure code, the Provider is certifying that the member was present at an eligible originating site when the Telehealth services were performed. Modifier GQ is required when applicable. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

NCCI Procedure to Procure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code the describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process claims. Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date

of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional claims (CMS 1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete

list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB-04 Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official UB-04 Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.

Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The 11-digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2-digit format (i.e. xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

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

Molina 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.

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and 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 as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of claims Molina paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide us, or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow

access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Corrected Claims

Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original claim number.

Claims submitted without the correct coding will be returned to the Provider for resubmission. Corrected claims must be submitted within twenty-four (24) months of the original claim remittance advice date.

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 or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within the minimum standards as set forth by the Office of the Insurance Commissioner (OIC) and HCA:

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

- Ninety-five (95%) percent of the monthly volume of claims shall be paid or denied within 60 calendar days of receipt by Molina Healthcare.
- Ninety-nine (99%) percent of all claims shall be paid or denied within 90 calendar days of receipt by Molina Healthcare.

The receipt date of a Claim is the date Molina receives notice of the Claim.

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

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

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

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

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

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the remittance advice and claim information to:

Molina Healthcare of Washington, Inc.
PO Box 30717
Los Angeles, CA 90030-0717

Claim Disputes/Reconsiderations

For Claims dispute resolutions see Provider Dispute and Member Appeals section

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- In accordance with WAC 182-502-0160, a contracted provider may only bill fee-for-service or managed care clients for covered health care services, if the Member and the provider both sign Health Care Authority form 13-879 "Agreement to Pay for Healthcare Services" no more than 90 days prior to services being rendered. The form must be completed in full. For Members with limited English proficiency, form 13-879 must be translated into the Member's primary language. If necessary, this form must also be interpreted for the Member. If the agreement is interpreted, the interpreter must also sign it. All other requirements for form 13-879 apply.
- Providers must accept payment by Molina Healthcare as payment in full in accordance with 42 CFR 447.15. Balance billing is not permitted. For additional information, refer to WAC 182-502-0160 and HCA Memo #10-25.
- Provider may not bill a Molina 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 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 Provider, capitated Provider, or organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and Healthcare Effectiveness Data and Information Set (HEDIS®) reporting.

Encounter data must be submitted at least once per month, and within your contracts timely claims filing requirements in order to meet State and Centers for Medicare & Medicaid Services (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.

Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

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

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two (2) types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

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

Behavioral Health providers will submit claims and encounter data based on the IMC SERI Guide (www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri) unless otherwise specified in their contract.

Integrated Managed Care (IMC) Specialty Behavioral Health Providers

Behavioral Health Supplemental Transactions

As of January 1st, 2020, each mental health and/or substance use disorder provider is required to collect behavioral health supplemental transactions associated with Medicaid members assigned to Molina Healthcare. Individual treatment practitioners

practicing outside of a licensed behavioral health agency (BHA), including prescribers (i.e. buprenorphine providers) are the only exception to this requirement and supplemental transaction reporting is not limited to the type or level of service provided. This data is used for state and federal regulatory reporting, as well as supporting the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMS) reporting requirements.

Providers must submit data per the requirements outlined in the HCA Behavioral Health Supplemental Transaction Data Guide.

At a later date, Molina will provide additional details on the format and system to be used for collection of the data transactions.

Evidence/Research Based Practices

Per Washington State Legislation, HCA is required to collect information on which Evidence/Research Based Practices (E/RBPs) for children under the age of 18 who are covered under Apple Health Medicaid. Providers must refer to and follow the Evidence Based Practice Institute's 2020 Reporting Guide for E/RBPs and the Service Encounter Reporting Instructions (SERI) when submitting EBP to Molina through claims or encounters. Technical assistance will be provided as needed. Molina transmits this information directly to HCA in a series of reports, per contractual requirements.

Providers are required to participate in approved E/RBPs trainings as outlined in the Evidence-Based Practice Reporting Guides or as approved by the Evidence-Based Practice Institute. For the Evidence-Based Practices Reporting Guide and additional E/RBP information please refer to https://www.hca.wa.gov/about-hca/behavioral-health-recovery/evidence-based-and-research-based-practices. Molina will provide additional support or assistance as needed to meet these requirements.

Rosters

The roster template has been vetted and agreed upon by all Managed Care Organizations (MCOs) in Washington State. There is an "Instructions" tab for samples and explanation of each data point included in the roster.
"Roster_Template_Practitioner" tab must be completed in order for Molina's system and provider directory to be updated correctly. The "Behavioral Health" tab is not required by Molina, however may be required for other MCOs. The Roster template can be found by logging in our provider portal (https://provider.MolinaHealthcare.com) and going to Forms tab.

Rosters need to be submitted to mhwproviderinfo@molinahealthcare.com for processing. Updates are required, at a minimum, on a quarterly basis.

Late or incorrect roster updates may result in claim denials.

Helpful hints for completing the IMC rosters:

- Include agency name in file name (e.g. “ABC BH Agency – All MCO_BH Roster Template….”)
- Add/Change/Term (Column A):
    - Comments in column A should reflect the CURRENT updates for your group; remove any comments already submitted to Molina on previous rosters.
    - Changes in this column should be specific (i.e. add, term, license/degree change, location add/term, update Medicaid ID) otherwise we may not know what has changed or been updated. It is important to note the effective date of the change in the Effective Date/Termination Date column (Column B).
- Practitioner NPI (Column D):
    - Each provider on the roster must have an individual NPI in order to be loaded in our system.
- ProviderOne ID#/Medicaid ID (Column K):
    - You may submit a provider on the roster even if their ProviderOne number is pending. Please update once available.
- Degree/Title (Column L):
    - Title should be based on licensure or taxonomy, not agency specific title (e.g. Agency Affiliated Counselor- we cannot determine degree level by that title.)
    - Please be sure to list the appropriate corresponding degree level if it is not obvious by the title, to ensure the correct rates are loaded. Examples are:
        - Psychiatrist (MD/DO)
        - Nurse Practitioner (NP)
        - Physician Assistant (PA)
        - Registered Nurse (RN/ARNP)
        - License Practical Nurse (LPN)
        - Psychologists (PhD/PsyD)
        - Masters-Level Providers (CSW/LCSW/LMFT/LMHC/MA/MBA/MC/MPA/MS/MSN/MSS/MSSA/MSW)
        - Bachelors, AA, or Other (BA/BAS/BS/BSW/AA)
        - Peer Counselor (HS)
        - Certified Medical Assistant (CMA)

        - Other (Clinical Staff)
        - Chemical Dependency Professional (CDP) – specify Bachelor's or Masters level if needed based on contract
        - Chemical Dependency Professional Trainee (CDPT) – specify Bachelor's or Masters level if needed based on contract

- Primary Specialty (Column V):
    - You are not limited to the specialties listed on the "Key-Specialties" tab, it is not inclusive of all IMC related behavioral health specialties.
    - Please only list one specialty in the Primary Specialty column. Additional Specialties can be listed in the Secondary Specialty column (Column AA).

- Primary Specialty Taxonomy (Column W):
    - List Federal taxonomy that is registered with HCA for each provider. We do not need the HCA specific taxonomies, with the exception of the Certified Medical Assistants (see below).
    - Certified Medical Assistant Taxonomy: there is no federally recognized taxonomy for this, so please use the HCA taxonomy (101Y99993L).

- Group NPI (Column AH) should be reflective of the group billing NPI, as it will appear in box 33a of claims.
- Group/Practice Name (Column AG) should be the group billing name, as it will appear in box 33 of claims.
- Location (Columns AI-AQ):
    - If a provider is practicing at multiple locations, please list each location on a separate row. Indicate which location is primary.

Claims and Encounter Submission

For instructions and guidance on submitting behavioral health claims and encounters, please refer to the MHW Claims & Encounter Companion Guide: Coming Soon!

For general instructions on how to submit behavioral health claims and encounters, please refer to the MHW Introduction to Claims & Encounters page: https://www.molinahealthcare.com/~/media/Molina/PublicWebsite/PDF/providers/wa/medicaid/MHW-Introduction-to-Claims-and-Encounters.pdf

Late or incorrect roster updates may result in claim denials.

11. Provider Dispute Resolution and Member Appeals

Member Grievances
A member has a right to file a complaint/grievance at any time about:

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

Members can file a grievance the following ways:
Mail:
Molina Healthcare
Attention: Member Appeals
P.O. Box 4004
Bothell, WA 98041-4004

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

Notification/Resolution of Grievances
We will let the member know we received their grievance within two business days. We will resolve the grievance within 45 calendar days and notify the member how it was resolved.

If a member has concerns about behavioral health needs, an Ombuds is can help them with questions and filing grievances. Visit www.MolinaHealthcare.com/waombuds to see a list of regional Ombuds representatives.

Member Appeals
Members can appeal our decision if a service was denied, reduced, or ended early. Here are the steps in the appeal process:

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

Continuation of Services During the Appeal Process

If a member wants to keep receiving previously approved services while we review the appeal, the appeal must be filed within 10 calendar days of the date on the denial letter. If the final decision in the appeal process agrees with our decision, the member may need to pay for services they received during the appeal process.

STEP 1 – Molina Healthcare Appeal

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

The member or their representative may request an appeal over the phone, in person, or in writing. If member requests an appeal by phone, they must also send it in writing to us with their signature. Additional information to support the appeal may be submitted over the phone, in writing, or in person. Within five calendar days, we will let the member know in writing that we received the appeal.
Members can file an appeal the following ways:

Mail:
Molina Healthcare
Attention: Member Appeals
P.O. Box 4004
Bothell, WA 98041-4004

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

A member may choose someone, including a lawyer or provider, to represent them and act on their behalf, however they must sign a consent form allowing this person to represent them. It is the member's responsibility to cover any fees or payments to representatives.

Before or during the appeal, the member or their representative may request copies of all the documents in the appeal file, and the guidelines or benefit provisions used to make the decision, free of charge. Molina Healthcare will send our decision in writing within 14 calendar days, unless we notify them, we need more time. Our review will not take longer than 28 calendar days.

If the member needs an expedited decision because the member's health is at risk, call (800) 869-7165 / TTY 711 for a quick review (called "expedited" review) of the denial. Members can file an expedited appeal either orally or in writing. Molina Healthcare will contact the member with our decision within 72 hours of receiving the request for an expedited review.

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

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

STEP 2 – State Administrative Hearing

If a member disagrees with Molina Healthcare's appeal decision, they can ask for a State Administrative Hearing. Members must ask for a hearing within 120 calendar days of the date on the appeal decision letter. A provider may not ask for a hearing on behalf of a member. An expedited decision can be requested if the member's health is at risk.

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

Members may consult with a lawyer or have another person represent them at the hearing. Members can get help finding a lawyer by checking with the nearest Legal Services Office or call the NW Justice CLEAR line at 1-888-201-1014 or visit their website at www.nwjustice.org.

If a member requests an expedited decision, a judge will make a decision within four working days after receiving the request. If the judge decides that the member's health is not a risk, OAH will call and send a letter within four working days of the request. The hearing will change to the standard timeframe.

STEP 3 - Independent Review

If a member does not agree with the decision from the State Administrative Hearing, they can ask for an Independent Review within 21 calendar days of the hearing decision or go directly to Step 4. Call (800) 869-7165 / TTY 711 for help. An expedited decision can be requested if the members health is at risk. Any extra information must be given to us within five working days of the request for the Independent Review. We will send the case to an Independent Review Organization (IRO) within three working days. Molina Healthcare will notify the member of the decision.

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

STEP 4 – Health Care Authority (HCA) Board of Appeals

A member can ask for a final review of their case by the HCA Board of Appeals Review Judge within 21 calendar days after the IRO decision is mailed. The decision of the HCA Board of Appeals is final.

Phone: (360) 725-0910; Toll-free: (844) 728-5212
Fax: (360) 507-9018
Address: P.O. Box 42700, Olympia, WA 98504-2700

Non-Covered Benefit

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

- It must be asked for before the member receives the service.
- To be approved, the provider must provide us with documentation that establishes that:
- The member's condition is different from most people
    - No other covered, less costly service will meet the member's need.
- The request must meet the rules in Washington Administrative Code (WAC) 182-501-0160 for approval.

ETR decisions are final and cannot be appealed. You can find an ETR Form here.

Note: A member can ask for an appeal at the same time a provider asks for an Exception to Rule.

Limited Benefit

Limitation Extension: Providers may ask Molina Healthcare to approve more services above and beyond the regular benefits. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in Washington Administrative Code (WAC) 182-501-0169:

- It must be asked for before the member receives more of the service.
- The member's condition must show it is improving due to the services already received.
- The member's condition must show it will likely continue to improve with more services, and that it will likely worsen without continued services.

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

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

Provider Dispute Resolution Process

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

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

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

Provider WebPortal (https://provider.MolinaHealthcare.com)

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

The benefits of submitting your dispute request electronically via the WebPortal at https://provider.MolinaHealthcare.com include:

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

Fax & Email

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

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

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

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

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

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

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

- Kaiser Foundation Health Plan of the Northwest:
  Kaiser Permanente NCA NW Claims

Waterpark 1
2500 Havana St.
Aurora, CO 80014

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

Code Edit Policy Reconsiderations

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

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

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

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

Reporting

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

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

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than 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.)

12. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure that Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina provider services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of Practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers

- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

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

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner fails provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The

attestation must be signed within 120 days. Application must include all required attachments.

- **License, Certification or Registration** – Provider must hold a current and 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. Telemedicine Practitioners are required to be licensed in the State where they are located, and the State the Member is located.
- **DEA or CDS Certificate** – Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a Practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the Practitioner is not eligible to participate in the Molina network.
- **Specialty** – Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education**–Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training** – Providers must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a 3year residency or is not board certified, the podiatrist must have 5 years of work history practicing podiatry.
- **Fellowship Training** – If the Provider is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program

from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent 5 years without any gaps in work history. Molina will consider allowing a practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or Wound Care. General Practitioners providing only wound care services do not require 5 years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work History** – Provider must supply most recent 5years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds 6 months, the Practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds 1year, the Practitioner must clarify the gap in writing.
- **Malpractice History** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply 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 Practitioner 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 Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioner 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 Practitioner. Molina will also verify all licenses, certifications and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner 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.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner 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. Practitioner 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 Practitioner. Practitioner 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 Practitioner.
- **Medicare Opt Out** – Practitioners 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.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners 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.

[3] If a practitioner's application is denied solely because a practitioner 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 practitioner may reapply as soon as practitioner 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 year from the date of original denial.

- **Inability to Perform** – Practitioner must disclose any inability to perform essential functions of a practitioner 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 Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any criminal convictions. Practitioners must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

Integrated Managed Care (IMC) Specialty Behavioral Health Providers

Molina credentials IMC Specialty Behavioral Health Agencies at the facility level, as they often employ lower level providers that cannot be individually credentialed (e.g. peers). The process involves completing an HDO (Health Delivery Organization) application and submitting a complete provider roster (see more information about Rosters under the Claims and Compensation section of this manual).

The following credentialing documents must be completed to initiate the process:

- Health Delivery Organization (HDO)*
- Completed CMS Ownership Form with recent signature*
- Completed Release Form with recent signature*
- Copy of Current State License
- Copy of Most Recent CMS Survey or Accreditation Certificate
- Copy of Current Liability Insurance
- Copy of W-9
- Roster of affiliated practitioners (if applicable) (name, specialty, NPI, scope of service (PCP/Specialist)

*Credentialing documents are located in the Credentialing/Contracting section of the Frequently Used Forms section of the Molina website: www.molinahealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

Please be sure to register your NPI with Health Care Authority (HCA) at www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider. This is a federal requirement in order for our plan to enroll providers. If you have questions regarding this requirement, please direct them to HCA at (800) 562-3022 ext. 16137.

You are required to maintain your NPI registration; voluntary or involuntary termination of your NPI may result in your termination from Molina Healthcare of Washington.

Agencies that are credentialed at the facility level will appear in the Molina Provider Online Directory at the agency level. Individual providers will not be listed in the directory unless they have been individually credentialed.

Re-credentialing is completed at least every 3 years, or as indicated by the credentialing committee.

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

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

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

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

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

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

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

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

The only items in the file that may be copied by the Practitioner are documents, which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within 2 working days. Molina will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Notification of Credentialing Decisions

Molina will make a determination to approve or deny a credentialing application no later than 90 days after receiving a complete application from a Practitioner.

A letter is sent to every Practitioner with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina

network. This notification is sent within 15 calendar days of the decision. Copies of the letters are filed in the Practitioner's credentials files.

Recredentialing

Molina recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** – Monitor for State Medicaid exclusions through each State's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.

- **National Practitioner Database** – Molina enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Providers sanctioned with SAM.

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

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

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider's contract based on quality of care or professional conduct, a certified letter is sent to the Provider describing the adverse action taken and the reason for the action, including notification to the Provider of the right to a fair hearing when required pursuant to Laws or regulations.

13. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Medical Management
2. Credentialing and Recredentialing
3. Sanction Monitoring for employees and contracted staff at all levels
4. Claims
5. Complex case management
6. CMS Preclusion List Monitoring
7. Other clinical and administrative functions

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet National Committee for Quality Assurance© (NCQA) criteria for credentialing functions. Call Center, Claims Administration, Care Management and/or Utilization Management functions are generally only delegated to Vendors or full risk entities. Non-Emergent Medical Transportation (NEMT) may be delegated to Vendors who can meet Call Center, Claims Administration and/or NEMT requirements.

Note: The Molina Member's ID card will identify which group the Member is assigned. If Claims Administration and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations.

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

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Kaiser Foundation Health Plan of the Northwest	KPNW	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult)	Physical Health Services only: Waterpark 1 2500 Havana St	For Physical Health Services KPNW: Phone: (800) 813-2000

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

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

Delegation Criteria

Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted IPAs, Medical Groups, or Vendors. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

Care Management
To be delegated for Care Management functions, Medical Groups, IPAs and/or Vendors must:

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place. Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every 30 days after hire.
- Pass a care management pre assessment audit, based on NCQA federal and state requirements, and Molina business needs.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for care management delegates.
- Submit timely and complete Care Management delegation reports as detailed in the Delegated Services Agreement to the applicable Molina contact.
- Comply with all applicable federal and state Laws.

Note: Molina does not allow care management delegates to further sub-delegate care management activities.

A Medical Group, IPA, or Vendor may request Care Management from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Care Management responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, state and federal requirements for delegation.

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

Claims Administration
To be delegated for Claims Administration, Medical Groups, IPAs, and/or Vendors must do the following:

- Have a capitation contract with Molina and be in compliance with the financial reserve's requirements of the contract.

- Be delegated for UM by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
- Correct deficiencies within timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Molina.
- Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
- Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every 30 days.
- Agree to Molina's contract terms and conditions for Claims Delegates.
- Submit timely and complete Claims Administration delegation reports as detailed in the
- Delegated Services Addendum to the applicable Molina contact.
- Within 45 days of the end of the month in which care was rendered, provide Molina with the Encounter Data required by the state in a format compliant with HIPAA requirements.
- Provide additional information as necessary to load Encounter Data within 30 days of Molina's request.
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
- Comply with all applicable Federal and State Laws.
- When using Molina's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina's Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

A Medical Group, IPA, or Vendor may request Claims Administration delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-

assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Claims Administration responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

Organizations delegated for Claims and/or Encounters may have additional reports required to assist Molina Healthcare in fulfilling its oversight responsibilities.

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, Medical Groups, IPAs, and/or Vendors must:

- Pass Molina's credentialing pre-assessment with a score of at least 90%, which is based on NCQA credentialing standards.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG, SAM, Washington State Department of Health, News Releases and published state Medicaid exclusion and termination lists a minimum of every 30 calendar days.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against Centers for Medicare & Medicaid Services (CMS) Medicare Opt-Out Affidavits List a minimum of every 30 calendar days.
- Have a process for monitoring adverse events at least every six months
- 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 30 calendar days after hire.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina
- Agree to Molina's contract terms and conditions for credentialing delegates
- Submit timely and complete Credentialing delegation reports using the current version of the Standardized Delegate Roster Template which is also detailed in the Delegated
- Services Agreement to the applicable Molina contract
- Comply with all applicable federal and state laws
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members

- Enroll all practitioners National Provider Identifier (NPI) into Washington State ProviderOne and revalidate once every 5 years
- Submit a copy of current NCQA certification or accreditation document.

Note: If the Medical Group, IPA, or Vendor is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depends on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state and federal requirements and Molina business needs.

If the Medical Group, IPA, or Vendor sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA, and state and federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and at least annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

A Medical Group, IPA, or Vendor may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit a Credentialing Pre-Delegation survey, ongoing monitoring documentation, policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

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

Utilization Management (UM)
To be delegated for UM functions, Medical Groups, IPAs, and/or Vendors must:

- Have an UM program that has been operational at least one (1) year prior to delegation and includes an annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina's UM pre-assessment, which is based on NCQA, state and federal UM standards, and Molina Policies and Procedures with a score of at least 90%.

- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Ensure that only licensed physicians/dentists/pharmacists make medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every 30 calendar days after hire.
- Agree to Molina's contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services
- Agreement to the applicable Molina contact.
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.
- Comply with all applicable federal and state laws.

Note: If the Medical Group, IPA, or Vendor is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

Molina does not allow UM delegates to further sub-delegate UM activities.

A Medical Group, IPA, or Vendor may request UM delegation from Molina through Molina's Delegation Oversight Manager or through the Medical Group, IPA, or Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate UM responsibilities is based on the Medical Group, IPA, or Vendor's ability to meet Molina, State and Federal requirements for delegation.

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

Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider Organizations. Molina will include all network Providers, including those in Medical Groups, IPAs, or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider Organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA, or Vendor's Quality Improvement Program.

Capitation Models

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

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

Full Risk/Global Capitation: IPA or PHO receives a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare. These services are typically global in nature (i.e., these groups have assumed financial responsibility for all covered health care services unless specifically carved out by Molina Healthcare). Financial responsibility for all services (including carve outs) is defined in the financial responsibility matrix attached to the full risk/global Capitation agreement.

Financial Viability of Capitated Organizations

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

Physician Incentive Plan (PIP)

Every year, Molina Healthcare is required to submit a report to HCA disclosing incentive terms for all Provider contracts. For Providers/Provider groups with substantial financial risk (any organization that could be adversely or positively affected financially by the

referral volume of its Members), Molina Healthcare is required to disclose additional documentation.

Organizations with substantial financial risk must provide information to Molina Healthcare including:

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

Reporting Requirements of Organizations

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

Complete quarterly financial statements including:

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

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

Capitation Operations

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

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

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

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

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

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

Encounter Reporting

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

HCA's hospital rate setting, the quality improvement program and Healthcare Effectiveness Data and Information Set (HEDIS®) reporting.

The encounter data reporting specifications can be found at www.molinahealthcare.com/providers/wa/medicaid/PDF/MHW-Introduction-to-Claims-and-Encounters.pdf.

Sanction Monitoring

All sub-contractors of Molina are required to show proof of processes to screen staff and employees at all levels against Federal exclusions lists. Screening must be done prior to the employee/staff's hire date and occur monthly thereafter. Molina will include a Sanction Monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation. Audits will be conducted within 3 years following pre-assessment audit of Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists.

Sanction Monitoring functions may be delegated to entities which meet Molina criteria. To be delegated for sanction monitoring functions, Providers must:

- Pass Molina's sanction monitoring pre assessment, which is based on Centers for Medicare & Medicaid Services (CMS) standards.

- Demonstrate that employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and every 30 calendar days thereafter.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for sanction monitoring delegates.
- Submit timely and complete Sanction Monitoring delegation reports during audit conducted every 3 years.
- Comply with all applicable federal and state laws.
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to Molina Members.

Delegation Reporting Requirements

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

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

14. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high quality, cost effective drug therapy. Molina works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) and Washington State Drug Utilization Review (DUR) Board meet quarterly to review and recommend medications for formulary consideration. The P&T Committee and Washington State DUR Board are organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting www.MolinaHealthcare.com or calling Molina at (855) 322-4082.

Drug Formulary

The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit www.MolinaHealthcare.com.

Information on procedures to obtain these medications is described within this document and also available on the Molina website at www.MolinaHealthcare.com.

Formulary Medications

In some cases, Members may only be able to receive certain quantities of medication. Information on limits are included and can be found in the formulary document.

Formulary medications with PA may require the use of first-line medications before they are approved.

Quantity Limitations

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Second Opinion Program

The Second Opinion Program is designed to improve prescribing practices for children ages 17 and younger. In collaboration with The Pediatric Mental Health Advisory Group and the Drug Utilization Review Board, the agency established pediatric mental health guidelines to identify children who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers.

The guidelines include, but are not limited to, the following:

- Alpha-agonist age and dose limits
- Antidepressant therapy duplications
- Antipsychotic age and dose limits
- Antipsychotic therapy duplications
- Attention deficit hyperactivity disorder (ADHD) age and dose limits
- ADHD therapy duplications
- Insomnia medications
    - Mental Health Polypharmacy (medication therapy includes five or more mental health drugs)

For more information on the second opinion program and the pediatric mental health guidelines, see the HCA Second Opinion Program webpage at www.hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-second-opinion-program .

Non-Formulary Medications

Nonformulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form. Clinical evidence must be provided and is considered when evaluating the request to determine medical necessity. The form can be found at: https://www.molinahealthcare.com/~/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/prior-auth-pharmacy.pdf

Generic Substitution

Generic drugs should be dispensed when available. If the use of a particular brand name becomes medically necessary as determined by the Provider, Prior Authorization must be obtained through the standard Prior Authorization process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first 6 months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

Medications not covered by Medicaid excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit.

Submitting a Prior Authorization Request

Molina will only process a completed PA request forms, the following information MUST be included for the request form to be considered complete.

- Member first name, last Name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing Molina will either fax or call your office to request clinical information be sent in to complete review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication PA Request form to Molina at (800) 869-7791. A blank Medication PA Request Form may be obtained by accessing www.MolinaHealthcare.com or by calling (855) 322-4082. The form can be found at: https://www.molinahealthcare.com/~/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/prior-auth-pharmacy.pdf

Member and Provider "Patient Safety Notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA© (National Committee for Quality Assurance) accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using national drug codes (NDCs) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications maybe covered through the

medical benefit using Healthcare Common Procedure Coding System (HCPC) J-codes via paper or electronic medical claim submission.

Molina, during the utilization management review process, will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any Federal or State regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

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

Newly FDA approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Pain Safety Initiative (PSI) Resources

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

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

On November 1st, 2017, the HCA implemented an opioid policy. The policy limits the number of pills prescribed for short-term use:

- For children age 20 or younger: 18 doses
  (1 tablet or 1 capsule or 1 suppository or 5 mL of a liquid)
- For adults age 21 or older: 42 doses

In addition, the HCA added a limit of 120MME per day on 11/1/19. For more information, see the HCA Opioid webpage at www.hca.wa.gov/billers-providers-partners/programs-and-services/opioids.

15. Risk Adjustment Management Program

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for Care Management referral.
- Ensure adequate resources for the acuity levels of Molina Members.
- Have the resources to deliver the highest quality of care to Molina Members.

Your Role as a Provider

As a Provider your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as this will ensure Molina receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g. diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a face to face visit with the Member.

- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Providers signature and credentials.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina is appropriate and accurate. All Claims/Encounters submitted to Molina are subject to State and/or Federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

For questions about Molina's Risk Adjustment programs, please contact our team at: RiskAdjustment.Programs@MolinaHealthcare.com