



Provider Manual

Molina Healthcare of New Mexico, Inc.

(Molina Healthcare or Molina)

Molina Marketplace

2020

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.

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Last Updated: 12/2019

Page 1

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Table of Contents

| | |
|---|-----------|
| Table of Contents | 2 |
| 1. Contact Information for Providers | 14 |
| Provider Services Department | 14 |
| Member Services Department..... | 14 |
| Claims Department | 14 |
| Claims Recovery Department | 15 |
| Compliance and Fraud AlertLine..... | 15 |
| Credentialing Department | 15 |
| Nurse Advice Line | 16 |
| Healthcare Services (UM) Department..... | 16 |
| Healthcare Services Authorizations & Inpatient Census | 17 |
| Health Management..... | 17 |
| Behavioral Health..... | 17 |
| Pharmacy Department | 18 |
| Quality..... | 18 |
| Molina Healthcare of New Mexico, Inc. Service Area..... | 19 |
| 2. Provider Responsibilities | 20 |
| Nondiscrimination of Health Care Service Delivery..... | 20 |
| Section 1557 Investigations | 20 |
| Facilities, Equipment and Personnel..... | 21 |
| Provider Data Accuracy and Validation..... | 21 |
| Molina Electronic Solutions Requirements | 22 |

| | |
|---|-----------|
| Electronic Solutions/Tools Available to Providers | 22 |
| Electronic Claims Submission Requirement..... | 22 |
| Manual Claims Submission | 23 |
| Electronic Payment (EFT/ERA) Requirement | 23 |
| Provider Portal | 24 |
| Balance Billing..... | 25 |
| Member Rights and Responsibilities | 25 |
| Member Information and Marketing | 25 |
| Member Eligibility Verification | 25 |
| Member Cost Share | 26 |
| Healthcare Services (Utilization Management and Case Management) | 26 |
| In Office Laboratory Tests | 26 |
| Referrals..... | 27 |
| Treatment Alternatives and Communication with Members | 27 |
| Pharmacy Program | 27 |
| Participation in Quality Programs | 27 |
| Compliance | 28 |
| Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions..... | 28 |
| Participation in Grievance and Appeals Programs | 28 |
| Participation in Credentialing..... | 28 |
| Delegation | 29 |
| 3. Cultural Competency and Linguistic Services | 30 |
| Background | 30 |

{00413751;1}

Last Updated: 12/2019

Page 3

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

| | |
|---|-----------|
| Nondiscrimination of Health Care Service Delivery | 30 |
| Cultural Competency | 31 |
| Provider and Community Training | 31 |
| Integrated Quality Improvement – Ensuring Access | 31 |
| Program and Policy Review Guidelines | 32 |
| 24 Hour Access to Interpreter Services | 32 |
| Documentation | 33 |
| Members who are Deaf or Hard of Hearing | 33 |
| Nurse Advice Line | 33 |
| 4. Member Rights and Responsibilities | 35 |
| Second Opinions | 35 |
| 5. Eligibility, Enrollment, Disenrollment & Grace Period | 36 |
| Enrollment in Molina Marketplace | 36 |
| Effective Date of Enrollment | 36 |
| Newborn Enrollment | 36 |
| Inpatient at time of Enrollment | 36 |
| Eligibility Verification | 37 |
| Eligibility Listing for Molina Marketplace Programs | 37 |
| Identification Cards | 37 |
| Molina Sample Member ID card | 37 |
| Disenrollment | 38 |
| Voluntary Disenrollment | 38 |
| Involuntary Disenrollment | 38 |

| | |
|---|-----------|
| PCP Suggested..... | 39 |
| PCP Changes | 39 |
| Grace Period | 39 |
| Grace Period Timing | 40 |
| Eligibility Messages..... | 40 |
| Notification | 41 |
| Prior Authorizations..... | 41 |
| Claims Processing | 42 |
| 6. Benefits and Covered Services..... | 43 |
| Member Cost Sharing | 43 |
| Link to Benefits Documents..... | 43 |
| Detailed Benefit Information | 43 |
| Obtaining Access to Certain Covered Services..... | 44 |
| Prescription Drugs..... | 44 |
| Injectable and Infusion Services..... | 45 |
| Access to Mental Health and Substance Abuse Services..... | 45 |
| Emergency Mental Health or Substance Abuse Services | 45 |
| Out of Area Emergencies..... | 46 |
| Obtaining Mental Health or Substance Abuse Services..... | 46 |
| Emergency Transportation | 46 |
| Non-Emergency Medical Transportation..... | 46 |
| Telehealth and Telemedicine Services | 46 |
| Preventive Care | 47 |

| | |
|--|-----------|
| Emergency Services | 47 |
| Nurse Advice Line | 47 |
| Health Management Programs | 48 |
| 7. Healthcare Services (HCS) | 49 |
| Introduction | 49 |
| Utilization Management (UM)..... | 49 |
| UM Decisions | 51 |
| Medical Necessity | 51 |
| Medical Necessity Review..... | 52 |
| Levels of Administrative and Clinical Review | 52 |
| Clinical Information..... | 53 |
| Prior Authorization..... | 53 |
| Requesting Prior Authorization..... | 54 |
| Emergency Services | 55 |
| Inpatient Management..... | 56 |
| Elective Inpatient Admissions..... | 56 |
| Emergent Inpatient Admissions..... | 56 |
| Inpatient at time of Termination of Coverage | 56 |
| Inpatient/Concurrent Review | 57 |
| Inpatient Status Determinations | 57 |
| Discharge Planning | 57 |
| Readmissions..... | 57 |
| Exceptions..... | 58 |

| | |
|--|-----------|
| Post Service Review | 58 |
| Affirmative Statement about Incentives | 59 |
| Open Communication about Treatment | 59 |
| Delegated Utilization Management Functions | 59 |
| Communication and Availability to Members and Providers..... | 60 |
| Out of Network Providers and Services..... | 60 |
| Coordination of Care and Services | 60 |
| Continuity of Care and Transition of Members..... | 61 |
| Reporting of Suspected Abuse and/or Neglect | 62 |
| Care Management | 63 |
| PCP Responsibilities in Care Management Referrals | 63 |
| Care Manager Responsibilities | 63 |
| Health Management..... | 64 |
| Pregnancy Notification Process | 65 |
| Case Management (CM)..... | 65 |
| 8. Quality | 67 |
| Maintaining Quality Improvement Processes and Programs..... | 67 |
| Patient Safety Program | 67 |
| Quality of Care | 68 |
| Medical Records | 68 |
| Medical Record Keeping Practices | 68 |
| Content..... | 69 |
| Organization..... | 70 |

| | |
|--|----|
| Retrieval..... | 70 |
| Confidentiality..... | 70 |
| Access to Care..... | 71 |
| Appointment Access | 71 |
| Office Wait Time..... | 72 |
| After Hours | 73 |
| Appointment Scheduling | 73 |
| Women’s Health Access | 74 |
| Monitoring Access for Compliance with Standards | 74 |
| Quality of Provider Office Sites | 75 |
| Physical Accessibility | 75 |
| Physical Appearance | 75 |
| Adequacy of Waiting and Examining Room Space | 75 |
| Advance Directives (Patient Self-Determination Act) | 76 |
| Services to Enrollees Under Twenty-One (21) Years of Age | 78 |
| Well Child/Adolescent Visits..... | 78 |
| Monitoring for Compliance with Standards..... | 79 |
| Quality Improvement Activities and Programs..... | 79 |
| Health Management..... | 79 |
| Care Management | 79 |
| Clinical Practice Guidelines..... | 79 |
| Preventive Health Guidelines | 80 |
| Cultural and Linguistic Services | 81 |

| | |
|---|-----------|
| Measurement of Clinical and Service Quality..... | 81 |
| Healthcare Effectiveness Data and Information Set (HEDIS®)..... | 81 |
| Qualified Health Plan (QHP) Enrollee Experience Survey | 82 |
| Behavioral Health Survey..... | 83 |
| Provider Satisfaction Survey | 83 |
| Effectiveness of Quality Improvement Initiatives | 83 |
| Quality Rating System..... | 83 |
| What Can Providers Do?..... | 84 |
| 9. Compliance..... | 85 |
| Fraud, Waste, and Abuse..... | 85 |
| Regulatory Requirements..... | 85 |
| Definitions | 86 |
| Examples of Fraud, Waste and Abuse by a Provider | 86 |
| New Mexico Insurance Fraud Act | 87 |
| Examples of Fraud, Waste, and Abuse by a Member | 88 |
| Review of Provider Claims and Claims System | 88 |
| Prepayment Fraud, Waste, and Abuse Detection Activities | 88 |
| Post-payment Recovery Activities | 89 |
| Claim Auditing..... | 90 |
| Provider Education..... | 91 |
| Reporting Fraud, Waste and Abuse | 91 |
| HIPAA Requirements and Information | 92 |
| Molina’s Commitment to Patient Privacy..... | 92 |

| | |
|---|-----------|
| Provider Responsibilities | 92 |
| Applicable Laws | 93 |
| Uses and Disclosures of PHI..... | 93 |
| Confidentiality of Substance Use Disorder Patient Records..... | 94 |
| Inadvertent Disclosures of PHI..... | 94 |
| Written Authorizations | 95 |
| Patient Rights..... | 95 |
| HIPAA Security | 96 |
| HIPAA Transactions and Code Sets | 96 |
| Code Sets | 97 |
| National Provider Identifier | 97 |
| Additional Requirements for Delegated Providers..... | 97 |
| Reimbursement for Copies of PHI..... | 97 |
| 10. Claims and Compensation | 99 |
| Claim Submission | 99 |
| Manual Claims Submission | 99 |
| Required Elements..... | 100 |
| National Provider Identifier (NPI)..... | 101 |
| Electronic Claims Submission | 101 |
| Provider Portal | 101 |
| Clearinghouse | 101 |
| EDI Claims Submission Issues | 102 |
| Coordination of Benefits (COB) and Third Party Liability (TPL)..... | 102 |

| | |
|--|------------|
| Timely Claim Filing..... | 102 |
| Reimbursement Guidance and Payment Guidelines..... | 103 |
| General Coding Requirements..... | 103 |
| CPT and HCPCS Codes | 104 |
| Modifiers..... | 104 |
| ICD-10-CM/PCS codes | 104 |
| Place of Service (POS) Codes | 104 |
| Type of Bill | 105 |
| Revenue Codes | 105 |
| Diagnosis Related Group (DRG)..... | 105 |
| Coding Sources..... | 105 |
| Definitions | 105 |
| Claim Auditing..... | 106 |
| Corrected Claims | 107 |
| EDI (Clearinghouse) Submission | 107 |
| Timely Claim Processing..... | 107 |
| Electronic Claim Payment | 108 |
| Overpayments and Incorrect Payments Refund Requests..... | 108 |
| Claim Disputes/Reconsiderations | 108 |
| Billing the Member | 109 |
| Fraud and Abuse..... | 109 |
| Encounter Data | 109 |
| 11. Complaints, Grievance and Appeals Process | 111 |

| | |
|--|------------|
| Provider Complaints and Grievances..... | 111 |
| Provider Grievances..... | 111 |
| Provider Credentialing Grievances..... | 113 |
| Addendum A - State Specific Reimbursement Requirements, Claims Payment, and Interest Calculations..... | 115 |
| Member Grievances..... | 117 |
| 12. Credentialing and Recredentialing | 119 |
| Non-Discriminatory Credentialing and Recredentialing..... | 119 |
| Type of Practitioners Credentialed & Recredentialied..... | 119 |
| Criteria for Participation in the Molina Network | 120 |
| Notification of Discrepancies in Credentialing Information & Practitioner’s Right to Correct Erroneous Information | 125 |
| Practitioner’s Right to Review Information Submitted to Support Their Credentialing Application..... | 125 |
| Providers’ Right to be Informed of Application Status | 126 |
| Notification of Credentialing Decisions..... | 126 |
| Excluded Providers | 127 |
| Ongoing Monitoring of Sanctions | 127 |
| Provider Appeal Rights..... | 128 |
| Reimbursement upon Delay in the Credentialing Process | 128 |
| Credentialing and Payment Dispute Resolution | 129 |
| 13. Delegation..... | 131 |
| Delegation Criteria | 131 |
| Credentialing | 131 |
| Delegation Reporting Requirements | 132 |

| | |
|--|------------|
| CMS Preclusion List..... | 132 |
| 14. Pharmacy | 133 |
| Pharmacy and Therapeutics Committee | 133 |
| Pharmacy Network..... | 133 |
| Drug Formulary | 133 |
| Formulary Medications..... | 133 |
| Quantity Limitations..... | 133 |
| Age Limits | 134 |
| Non-formulary Medications | 134 |
| Generic Substitution..... | 134 |
| New to Market Drugs..... | 134 |
| Medications Not Covered..... | 134 |
| Submitting a Prior Authorization Request..... | 134 |
| Member and Provider “Patient Safety Notifications”..... | 135 |
| Specialty Pharmaceuticals, Injectable and Infusion Services..... | 135 |
| Pain Safety Initiative (PSI) Resources..... | 136 |
| 15. Risk Adjustment Management Program | 137 |
| What is Risk Adjustment? | 137 |
| Why is Risk Adjustment Important? | 137 |
| Your Role as a Provider | 137 |
| RADV Audits | 137 |
| Contact Information..... | 138 |

1. Contact Information for Providers

Provider Services Department

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

Address: Molina Healthcare of New Mexico, Inc.
400 Tijeras NW, Suite 500
Albuquerque, NM 87102

Phone: (855) 322-4078

Fax: (505) 798-7313

Member Services Department

The Member Services department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Practitioners (PCPs), and Member complaints. Member Services representatives are available 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding State holidays.

Address: Molina Healthcare of New Mexico, Inc.
400 Tijeras NW, Suite 500
Albuquerque, NM 87102

Phone: (855) 322-4078

TTY: 711

Claims Department

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

- Access the Provider Portal (<https://provider.MolinaHealthcare.com>)
- EDI Payer ID 09824

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions, contact Provider Services at (855) 322-4078.

{00413751;1}

Last Updated: 12/2019

Page 14

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Claims Recovery Department

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

Address: Molina Healthcare of New Mexico, Inc.
PO Box 22801
Long Beach, CA 90801

Phone: (855) 322-4078

Compliance and Fraud AlertLine

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

Phone: (866) 606-3889

Website: <https://MolinaHealthcare.alertline.com>

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Address: Molina Healthcare of New Mexico, Inc.
400 Tijeras NW, Suite 500
Albuquerque, NM 87102

Phone: (855) 322-4078

Fax: (505) 798-7313

Nurse Advice Line

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

24 hours per day, 365 days per year

English Phone: (888) 275-8750

Spanish Phone: (866) 648-3537

TTY/TDD: 711 Relay

Healthcare Services (UM) Department

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

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

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

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

- Submit requests directly to Molina via the Provider Portal. See Molina's Provider Portal Quick Reference Guide or contact your Provider Services representative for registration and submission guidance.

Healthcare Services Authorizations & Inpatient Census

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

Address: Molina Healthcare of New Mexico, Inc.
400 Tijeras NW, Suite 500
Albuquerque, NM 87102

Phone: (888) 472-9483

Fax: (888) 802-5711

Health Management

Molina's Health Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Weight Management and Smoking Cessations Programs

Phone: (866) 472-9483

Fax: (562) 901-1176

Health Management Programs

Phone: (866) 891-2320

Fax: (800) 642-3691

Behavioral Health

Molina manages all components of our covered services for behavioral health. For Member behavioral health needs, please contact Molina directly at:

Address: Molina Healthcare of New Mexico, Inc.
400 Tijeras NW, Suite 500
Albuquerque, NM 87102

Phone: (855) 322-4078

(24) Hours per day, (365) day per year: (888) 275-8750

{00413751;1}

Last Updated: 12/2019

Page 17

Pharmacy Department

Prescription drugs are covered by Molina, through CVS Caremark. A list of in-network pharmacies is available on the www.MolinaHealthcare.com website, or by contacting Molina at (505) 341-7493.

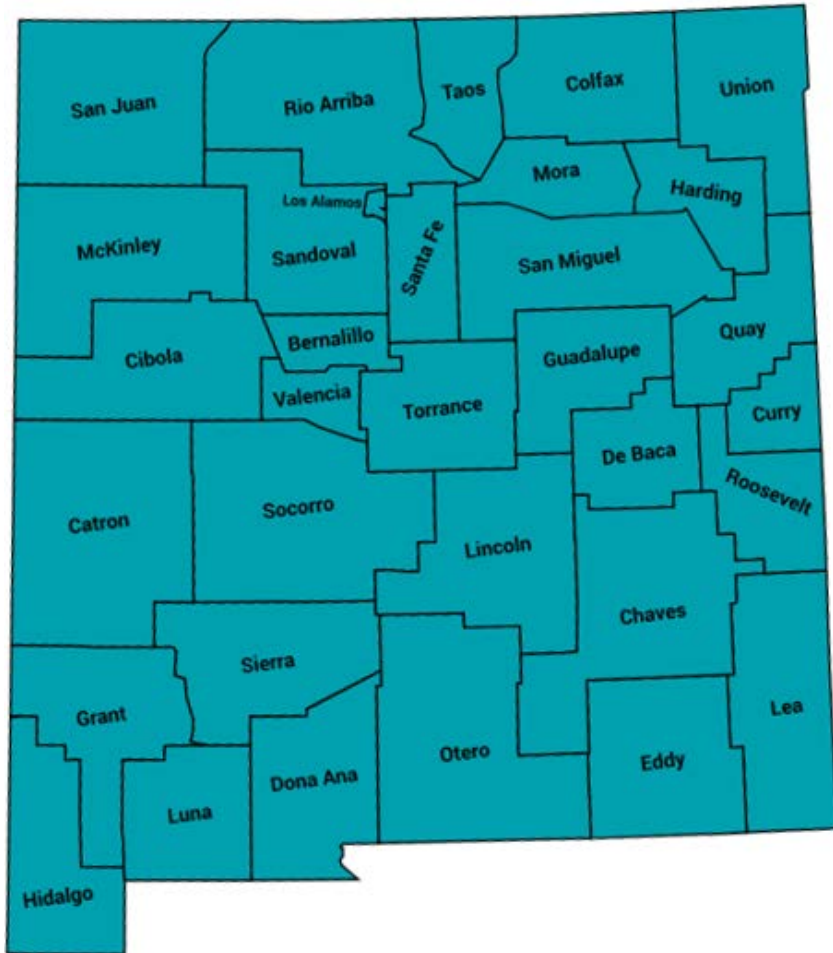
Quality

Molina maintains a Quality department to work with Members and Providers in administering Molina's Quality Programs.

Phone: (877) 377-9594

Fax: (877) 553-6508

Molina Healthcare of New Mexico, Inc. Service Area



Legend

Current Marketplace Service Area

2. Provider Responsibilities

Nondiscrimination of Health Care 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 Marketplace website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina Healthcare requires Providers to deliver health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, gender, race, color, national origin, ethnicity, ancestry, religion, sexual orientation, health status, disability, spousal affiliation or abuse status and without regard to the source of payments made for health care services rendered to a patient. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

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, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Toll Free: (866) 606-3889

TTY/TDD: 711

On Line: <https://MolinaHealthcare.AlertLine.com>

Email: civil.rights@MolinaHealthcare.com

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA® required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition or termination of a Provider (within an existing clinic/practice)
- Change in 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 <https://providersearch.MolinaHealthcare.com> 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 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

{00413751;1}

Last Updated: 12/2019

Page 21

otherwise impacts its membership or ability to coordinate Member care. Providers are required to provide timely responses to such communications.

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 Molina's Provider Portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina 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 Molina's 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 on our website at www.MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

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

Electronic Claims Submission Requirement

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

- Promotes HIPAA compliance.

{00413751;1}

Last Updated: 12/2019

Page 22

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

- 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 reach Molina faster.

Molina offers the following electronic Claims submission options:

- Submit claims directly to Molina via the Provider Portal. See our Provider Portal Quick Reference Guide <https://provider.MolinaHealthcare.com> or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 09824, refer to our website www.MolinaHealthcare.com for additional information.

While both options are embraced by Molina, submitting claims via Molina’s 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.

Manual Claims Submission

Providers may submit claims manually via U.S. mail or hand delivery. Providers may obtain standard forms for submitting claims or for coding changes from Molina.

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 RA processes. There is no cost to the Provider for EFT

{00413751;1}

Last Updated: 12/2019

Page 23

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 electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

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

Provider Portal

Providers are required to register for and utilize Molina's Provider Portal. Molina's Provider Portal is an easy to use, online tool available to all of our Providers at **no cost**. The Provider Portal offers the following functionality:

- Verify and print member eligibility.
- View benefits, covered services and Member health record.
- View Member roster of assigned membership for PCP(s).
- Claims Functions.
 - Professional and Institutional Claims (individual or multiple claims)
 - Receive notification of Claims status change
 - Correct Claims
 - Void Claims
 - Add attachments to previously submitted claims
 - Check Claims status
 - Export Claims reports
 - Create and manage claim templates
 - Open saved claims
- Prior Authorizations/Service Requests
 - Create and submit Prior Authorization/Service Requests
 - Check status of Authorization/Service Requests
 - Receive notification of change in status of Authorization/Service Requests
 - Create Service Request/Authorization Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
 - Create and submit a Claim Appeal
 - Add Appeal attachments to Appeal
 - Receive Email Confirmation

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

Balance Billing

Providers contracted with Molina cannot bill the Member for any covered services beyond applicable copayments, deductibles, or coinsurance. 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. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

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

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 in this Provider Manual.

Member Information and Marketing

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

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

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. A Provider must verify eligibility each time a Molina Member presents to their office for services. Payment for services rendered is based on enrollment and benefit eligibility.

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

{00413751;1}

Last Updated: 12/2019

Page 25

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Member Cost Share

Providers should verify the Molina Member's Cost Share status prior to requiring the Molina Member to pay co-pay, co-insurance, deductible or other Cost Share that may be applicable to the Member's specific Benefit Plan. Some plans have a total maximum Cost Share that frees the Member from any further out of pocket charges once reached (during that calendar year).

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management, 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 Provider Manual.

In Office Laboratory Tests

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

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (<https://providersearch.MolinaHealthcare.com/>) or call (855) 322-4078. For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

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

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

Referrals

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 and Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent 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 referral request to Molina.

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.

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:

{00413751;1}

Last Updated: 12/2019

Page 27

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews
- Delivery of Patient Care Information

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

Compliance

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

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

Molina requires that 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 protected health information (PHI). For additional information please refer to the Compliance section of this Provider Manual.

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 and/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 requests for information related to the credentialing or re-credentialing process.

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

{00413751;1}

Last Updated: 12/2019

Page 28

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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, gender, gender identity, sexual orientation, age and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at www.MolinaHealthcare.com, from your local Provider Services representative and by calling Molina Provider Services toll free at (855) 322-4078.

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 home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, gender, race, color, national origin, ethnicity, ancestry, religion, sexual orientation, health status, disability, spousal affiliation or abuse status and without regard to the source of payments made for health care services rendered to a patient. This requirement includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top fifteen (15) languages spoken in the State to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

{00413751;1}

Last Updated: 12/2019

Page 30

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Additionally, Participating Providers or contracted medical groups/Independent Practice 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.

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: <https://www.hhs.gov/civil-rights/for-providers/index.html>

Cultural Competency

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

Provider and Community Training

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

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

1. Written materials;
2. On-site cultural competency training;
3. Online cultural competency provider training; and,
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

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

{00413751;1}

Last Updated: 12/2019

Page 31

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e. 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; and,
 - Contracted Providers to assess gaps in network demographics.
- Revalidate date at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Needs Assessment).
- Applicable national demographics and trends derived from publicly available sources.
- 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 CAHPS® results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2020.

24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (855) 322-4078. If Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a language service Provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset.

{00413751;1}

Last Updated: 12/2019

Page 32

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 being notified of his or her right to have a qualified interpreter at no cost.

Members who are Deaf or Hard of Hearing

Molina Healthcare provides a TTY/TDD connection, which may be reached by dialing 711. This connection provides access to Member Services, Provider Services, Quality, Healthcare Services and all other health plan functions.

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

Molina will provide face-to-face service delivery for American Sign Language (ASL) to support our Members who are deaf or hard of hearing. Requests should be made three (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 Customer Services.

Nurse Advice Line

Molina provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other

languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Evidence of Coverage (EOC)

EOCs are available on Molina's [Member Website](#).

Member Rights and Responsibilities are outlined under the heading "your Rights and Responsibilities" within the EOC 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.

For additional information, please contact Molina toll free at (855) 322-4078, 8:00 a.m. to 5:00 p.m. Monday through Friday. TTY users, please call 711.

Second Opinions

If a Member does not agree with their Provider's plan of care, they have the right to request 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.

5. Eligibility, Enrollment, Disenrollment & Grace Period

Enrollment in Molina Marketplace

The Molina's Marketplace Program is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act. It is administered by the New Mexico Office of the Superintendent of Insurance.

To enroll with Molina, the Member, his/her representative, or his/her responsible parent or guardian must follow enrollment process established by the New Mexico Health Insurance Exchange will enroll all eligible Members with the health plan of their choice.

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

Coverage shall begin as designated by the New Mexico Health Insurance Exchange on the first day of a calendar month. If the enrollment application process is completed by the 15th of the month, the coverage will be effective on the first day of the next month. If enrollment is completed after the 15th of the month, coverage will be effective on the first day of the second month following enrollment.

Newborn Enrollment

When a Molina Marketplace Subscriber or their Spouse gives birth, the newborn is automatically covered under the Subscriber's policy with Molina for the first thirty-one (31) days of life. In order for the newborn to continue with Molina coverage past this time, the infant must be enrolled through the Marketplace Exchange with Molina on or before sixty (60) days from the date of birth.

PCP's are required to notify Molina via the Pregnancy Notification Report immediately after the first prenatal visit and/or positive pregnancy test for any Molina Member presenting themselves for health care services.

Inpatient at time of Enrollment

With Member assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior Insurer's liability for payment of Inpatient Hospital Services through discharge of any Inpatient admission. If there is no transition of care provision through Member's prior Insurer or Member did not have coverage through an

Insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of Member's coverage with Molina, not prior.

Eligibility Verification

Health Insurance Marketplace Programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Molina Marketplace Programs

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

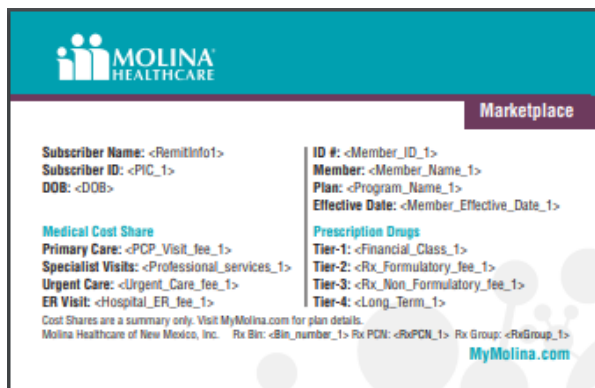
- Molina Provider Portal <https://provider.MolinaHealthcare.com>.
- Molina Provider Services automated IVR system toll free at (855) 322-4078

Possession of a Marketplace ID Card does not mean a recipient is eligible for Molina Marketplace services. A Provider should verify a recipient's eligibility each time the recipient presents to their office for services. The verification sources can be used to verify a recipient's enrollment in a Molina Marketplace plan.

Identification Cards

Molina Sample Member ID card

Card Front



Card Back



Members are reminded in their Agreement/COC/EOC/Policy to carry ID cards 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 Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to terminate coverage for any reason at any time. However, beyond the open-enrollment period, if a Member elects to terminate coverage with Molina Healthcare Marketplace, they are not eligible to re-enroll with another Marketplace health plan until the following year's open-enrollment period unless there is a qualifying life event, and they qualify for a Special Enrollment Period (SEP) or if they are American Indian or Alaska Native. Members may discontinue Molina Healthcare coverage by contacting the NM Health Insurance Exchange.

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

Involuntary Disenrollment

Under very limited conditions and in accordance with the Affordable Care Act guidelines, Members may be involuntarily disenrolled from a Molina Marketplace program. With proper written documentation and approval by the Centers for Medicaid and Medicare Services (CMS) or its Agent; the following are acceptable reasons for which Molina may submit Involuntary Disenrollment requests to CMS:

{00413751;1}

Last Updated: 12/2019

Page 38

- Delinquency of payment, past defined grace period(s)
- Member has moved out of the Service Area
- Member death
- Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness (this may not apply to Members refusing medical care)
- Member's utilization of services is fraudulent
- Member ages out of coverage (e.g., dependent child age > twenty-six (26))

PCP Suggested

Molina will offer each Member a choice of Primary Care Practitioners (PCPs). After making a choice, each Member will have a single PCP. Molina will suggest assignment of a PCP to those Members who did not choose a PCP at the time of Molina selection. Molina will take into consideration the Member's last PCP (if the PCP is known and available in Molina's contracted network), closest PCP to the Member's home address, ZIP code location, keeping Children/Adolescents within the same family together with the same PCP, age (adults versus Children/Adolescents) and gender (OB/GYN). Molina will allow pregnant Members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

PCP Changes

Members can change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes requested on or after the 26th of the month will be in effect on the first day of the second calendar month.

Grace Period

Definitions

APTC Member: A Member who receives advanced premium tax credits (premium subsidy), which helps to offset the cost of monthly premiums for the Member.

Non-APTC Member: A Member who is not receiving any advanced premium tax credits and is therefore solely responsible for the payment of the full monthly premium amount.

Member: An individual, including any dependents, enrolled in Molina Marketplace. This term includes both APTC Members and Non-APTC Members.

Summary

{00413751;1}

Last Updated: 12/2019

Page 39

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
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The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with State Law to Non-APTC Members who fail to pay their monthly premium by the due date. To qualify for a grace period, the Member must have paid at least one full month's premium within the benefit year. The grace period begins on the first day of the first month for which the Member's premium has not been paid. The grace period is not a "rolling" period. Once the Member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace Period Timing

Non-APTC Members:

Non-ATPC Members are granted a thirty-one (31) day grace period, during which they may be able to access some, or all services covered under their benefit plan. If the *full past-due premium* is not paid by the end of the grace period, the Non-APTC Member will be terminated retroactive to the last day of the month prior to the grace period.

APTC Members:

APTC Members are granted a three (3) month grace period. During the first month of the grace period Claims and authorizations will continue to be processed, including Pharmacy Claims. Services, authorization requests and Claims may be denied or have certain restrictions during the second and third months of the grace period. If the APTC Member's *full past-due premium* is not paid by the end of the third month of the grace period, the APTC Member will be retroactively terminated to the last day of the first month of the grace period.

Eligibility Messages

When a Member is in the grace period, Molina Healthcare, Inc. (Molina) will include an eligibility message on the Provider Portal, interactive voice response (IVR) and in the call centers. This alert message will provide information about the Member's grace period status, including which month of the grace period that the APTC Member is in the grace period (second or third) as well as information about how authorizations and Claims will be processed during this time. Providers should verify both the eligibility status AND any service messages when checking a Member's eligibility. For additional information about how authorizations and Claims will be processed during this time, please refer to the Member Evidence of Coverage, or contact Molina's Provider Services Department toll free at (855) 322-4078.

{00413751;1}

Last Updated: 12/2019

Page 40

Notification

All Members will be notified upon entering the grace period. Additionally, when an APTC Member enters the grace period, their eligibility status becomes available on the Provider Portal. The online eligibility notification will inform Providers as follows:

- Members who receive APTC and have entered the 1st month of the grace period will not have any service restrictions. Therefore, the message that Providers will see upon checking the provider portal will read as follows: No Enrollment Restrictions
- Providers will be notified and are able to check that the APTC Member entered the 2nd or 3rd months of the grace period
- All Providers and specifically, Providers who have submitted Claims for the APTC Member in the two months prior to the start of the grace period will be notified and are able to check that the APTC Member entered the 2nd or 3rd months of the grace period
- Providers will be notified and are able to check if the APTC Member is in the 2nd or 3rd months of the grace period before services are rendered and before submitting claims

The online eligibility notification will advise Providers that services rendered during the second and third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

Prior Authorizations

All authorization requests will be reviewed based on Medical Necessity and will expire after thirty (30) days. If a request for a prior authorization is made, the provider will receive the following disclaimer:

“Prior Authorization is a review of medical necessity and is not a guarantee of payment for services. Payment will be made in accordance with a determination of the member’s eligibility on the date of service (for Molina Marketplace members, this includes grace period status), benefit limitations/ exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement. If permitted under State law, Molina Healthcare will pend claims for services provided to Marketplace members in months 2 and 3 of the Federally-required grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional information on a Marketplace member’s grace period status, please contact Molina Healthcare.”

APTC Members:

{00413751;1}

Last Updated: 12/2019

Page 41

If the APTC Member pays the full premium payment prior to the expiration of the three (3) month grace period, Providers may then seek authorization for services. If the APTC Member received services during the second or third month of the grace period without a prior authorization, the Provider may request a retro-authorization for those services already rendered. All authorization requests will be reviewed based on Medical Necessity.

Non-APTC Members:

Authorization requests received during a Non-APTC Member's grace period will be processed according to Medical Necessity standards.

Claims Processing

APTC Members:

First Month of Grace Period: Clean Claims received for services rendered during the first month of a grace period will be processed using Molina's standard processes and in accordance with State and Federal statutes and regulations and within established turn-around-times.

Second/Third Month of Grace Period: Clean Claims received for services rendered during the second and third months of an APTC Member's grace period will be pended until the premium is paid in full. In the event that the APTC Member is terminated for failure to pay the *full premium* by the end of the grace period, Molina will deny Claims for services rendered in the second and third months of the grace period. Pharmacy Claims will be processed based on program drug utilization review and formulary edits; the APTC Member will be charged one-hundred percent (100%) of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-APTC Members:

Clean Claims received for services rendered during the grace period will be processed using Molina's standard processes and in accordance with State and Federal statutes and regulations and within established turn-around-times.

6. Benefits and Covered Services

Molina covers the services described in the Summary of Benefits and Schedule of Benefits documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina toll free at (855) 322-4078 from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Member Cost Sharing

Cost Sharing is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Molina Marketplace plan. The Cost Sharing amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card. Additional detail regarding cost sharing listed in the Schedule of Benefits. Cost Sharing applies to all Covered Services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). Cost Sharing towards Essential Health Benefits, other than those which are preventive, may be reduced or eliminated for certain eligible Members, as determined by Marketplace's rules.

It is the Provider's responsibility to collect the copayment and other Member Cost Share from the Member to receive full reimbursement for a service. The amount of the copayment and other Cost Sharing will be deducted from the Molina payment for all Claims involving Cost Sharing.

Link to Benefits Documents

The following web link provides access to the Summary of Benefits guides and Evidence of Coverage (EOC) documents for the Molina Marketplace products offered in New Mexico.

<https://www.molinahealthcare.com/members/nm/en-US/mem/marketplace/coverd/Pages/View-Our-2020-Plans.aspx>

Detailed Benefit Information

Detailed information about benefits and services can be found in the Schedule of Benefits booklets made available to Molina Marketplace Members via the Molina Member Portal. [Providers can access Schedule of Benefits documents via the Molina Provider Portal.](#) Link: www.MolinaHealthcare.com/provider

Obtaining Access to Certain Covered Services

Prescription Drugs

Prescription drugs are covered by Molina, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the www.MolinaHealthcare.com website, or by contacting Molina. Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina toll free at (855) 322-4078 or at www.MolinaMarketplace.com.

Non-Formulary Drug Exception Request Process

There are two (2) types of requests for clinically appropriate drugs that are not covered under the Member's Marketplace plan type:

- "Expedited Exception Request" for urgent circumstances that may seriously jeopardize life, health or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- "Standard Exception Request"
- The Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision no later than:
 - Twenty-four (24) hours following receipt of request for Expedited Exception Request
 - Seventy-two (72) hours following receipt of request for Standard Exception Request

If the initial request is denied, the Member and/or the Member's authorized representative may follow the Member Complaints, Grievance and Appeal Process, which may be found here: <https://www.molinahealthcare.com/members/nm/en-US/PDF/Marketplace/2019-summary-of-health-insurance-grievance-procedures-rev-1-4%20-2019-English.pdf>

The complete regulations for grievances and appeals are located at New Mexico Administrative Code §13.10.17. The text of these regulations can be found at: <http://164.64.110.134/parts/title13/13.010.0017.html>.

The contact information for Molina's Grievance and Appeals department is:

**Molina Healthcare of New Mexico
Grievance and Appeals Unit
400 Tijeras Ave. NW, Suite 200
Albuquerque, NM 87102**

Fax #: (505) 342-0583

E-Mail: Marketplace.Grievances@MolinaHealthCare.Com

Website: <https://www.molinahealthcare.com/members/nm/en-US/mem/marketplace/quality/Pages/gna.aspx>

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases they will be made available through a vendor, designated by Molina. More information about our Prior Authorization process, including a link to the PA request form, is available in the Healthcare Services section of this Provider Manual.

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

Access to Mental Health and Substance Abuse Services

Members in need of Mental Health or Substance Abuse Services can be referred by their PCP for services or Members can self-refer by calling Molina's Behavioral Health department toll free at (855) 322-4078. Molina's Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the EOCs linked above, or by contacting Molina. All outpatient professional mental health and substance abuse services will be charged the primary care copay equivalent. If inpatient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation, and inpatient member cost sharing will apply.

Emergency Mental Health or Substance Abuse Services

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

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

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Last Updated: 12/2019

Page 45

Out of Area Emergencies

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

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

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

Obtaining Mental Health or Substance Abuse Services

Please call the appropriate Member Services or Provider Services number or the Behavioral Health department to find a mental health or substance abuse Provider.

Emergency Transportation

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

Non-Emergency Medical Transportation

For Molina Marketplace Members, non-emergency Medically Necessary ground transportation is needed within Molina's Service Area to transfer the Member from one medical facility to another. Examples of this are from one hospital to another hospital, from a hospital to a nursing facility or hospice. Non-emergency medical transportation is provided by wheelchair lift equipped vehicle, litter/stretchers van or non-emergency ambulance (both advanced life support and basic life support). When non-emergency medical transportation is needed, Molina will arrange for the transportation to be provided by one of our Participating Provider transportation vendors. Please note this is not a service for which Members can self-refer and any services not arranged by Molina will not be covered.

Telehealth and Telemedicine Services

Members may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

{00413751;1}

Last Updated: 12/2019

Page 46

- 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
- Member cost sharing associates to the Summary of Benefits and Coverage, based upon the Participating Provider's designation for Covered Services. (i.e., Primary Care, Specialist or other Practitioner).
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.

Preventive Care

Preventive Care Guidelines are located on the Molina Website. Please use the link below to access the most current guidelines:

<https://www.MolinaHealthcare.com/providers/common/marketplace/resource/Pages/hlthguide.aspx>

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line toll free at (800) 377-9594.

Emergency Services

Emergency Services means: health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

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

Nurse Advice Line

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

24 hours per day, 365 days per year

English Phone: (888) 275-8750

Spanish Phone: (866) 648-3537

TTY/TDD: 711 Relay
Or (866) 735-2929 (English)
Or (866) 833-4703 (Spanish)

{00413751;1}

Last Updated: 12/2019

Page 47

Molina is committed to helping Molina Members:

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

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

Health Management Programs

Molina's health management programs provide patient education information to Members and facilitate Provider access to chronic disease programs and services.

For additional information on health management programs please refer to the Healthcare Services section of this Provider Manual.

7. Healthcare Services (HCS)

Introduction

Healthcare Services is comprised of Utilization Management and Care Management 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 using processes designed 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's UM department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. The UM team works closely with the Care Management team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. Molina's UM program ensures appropriate and effective utilization of services by:

- Managing benefits effectively and efficiently to ensure appropriate use of health care services.
- Identifying the review criteria, information sources, and processes that are used to review for medical necessity and appropriateness of the requested items and services.
- Coordinating, directing, and monitoring the quality and cost effectiveness of utilization practice patterns of Providers to identify over and under service utilization.
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals perform all components of the UM/CM processes while providing timely responses to Member appeals and grievances.

- Ensuring that UM decision tools are appropriately applied in determining medical necessity decisions.
- Identifying and assessing the need for Care Management through early identification of high or low service utilization and high cost chronic diseases.
- Promoting health care in accordance with local, state and national standards.
- Processing authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

Key Functions of the UM Program

All prior authorizations are based on a specific standardized list of services.

- **Eligibility and Oversight**
 - Eligibility verification.
 - Benefit administration and interpretation.
 - Ensure authorized care correlates to Member's medical necessity need(s) and benefit plan.
 - Verifying current Physician/hospital contract status.
 - Delegation oversight.
- **Resource Management**
 - Prior Authorization and referral management.
 - Pre-admission, Admission and Inpatient Review.
 - Post service/post claim audits.
 - Referrals for Discharge Planning and Care Transitions.
 - Staff education on consistent application of UM functions.
- **Quality Management**
 - Satisfaction evaluation of the UM program using Member and Provider input.
 - Utilization data analysis.
 - Monitor for possible over- or under-utilization of clinical resources.
 - Quality oversight.
 - 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 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 (888) 665-1328 to obtain Molina's UM Criteria.

Medical Necessity

"Medically Necessary" or **"Medical Necessity"** means health care services that a practitioner/physician, exercising prudent clinical judgment, would provide to a patient.

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

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

{00413751;1}

Last Updated: 12/2019

Page 51

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, CMS 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;

{00413751;1}

Last Updated: 12/2019

Page 52

- 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; and,
- The PCP is kept apprised 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 are encouraged to use the Molina prior authorization form provided on the Molina website. If using a different form, the prior authorization request must include the following information:

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

{00413751;1}

Last Updated: 12/2019

Page 53

- 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.
- 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 situation where the standard time frame or decision making process could seriously jeopardize the life or health of the enrollee or could jeopardize the enrollee's ability to regain maximum function. 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 twenty-four (24) hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provides notification within five (5) working days.

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 (888) 665-1328.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. 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 if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Requesting Prior Authorization

Provider Portal: Participating Providers are encouraged to use the Molina Provider Portal for prior authorization submissions whenever possible. Instructions for how to

{00413751;1}

Last Updated: 12/2019

Page 54

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

submit a prior authorization request are available on the Molina Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

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

Fax: The Prior Authorization form can be faxed to Molina toll free at (888) 802-5711.

Phone: Prior Authorizations can be initiated by contacting Molina's Healthcare Services department toll free at (888) 665-1328. 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 New Mexico, Inc.
Attn: Healthcare Services Dept.
400 Tijeras NW, Suite 500
Albuquerque, NM 87102

Emergency Services

Emergency Services means: Healthcare procedures, treatments, or services delivered to a covered person for an Emergency Medical Condition or Emergency.

Emergency Medical Condition or Emergency means the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a reasonable lay person to result in:

- Jeopardy to a person's physical or mental health or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part or disfigurement.

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

{00413751;1}

Last Updated: 12/2019

Page 55

Molina accomplishes this service by providing a twenty-four (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 twenty-four (24) hour Emergency Services for ambulance and hospitals. An out of network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment. Member payments to the non-participating facility will not apply to the Member's deductible or annual out-of-pocket maximum.

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

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

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all 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 emergent inpatient admissions within twenty-four (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 inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services.

{00413751;1}

Last Updated: 12/2019

Page 56

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 twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in a denial of authorization for the remainder of the inpatient stay 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 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).

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

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina will conduct 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.

- 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:
 - Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
 - Certain chronic conditions for which subsequent Readmissions are often either not preventable or are expected to require significant follow-up care.
 - Neonatal and obstetrical Readmissions.
 - Initial admissions with a discharge status of “left against medical advice” because the intended care was not completed.
 - Behavioral Health readmissions

When a subsequent admission to the same facility with the same or similar diagnosis occurs within twenty-four (24) hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

Exceptions

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

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

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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 affirms that all UM decision making is based solely on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.

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.

{00413751;1}

Last Updated: 12/2019

Page 59

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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 (888) 665-1328 during normal business hours, Monday through Friday (except for Holidays) from 8:00 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 twenty-four (24) hours a day, seven (7) days a week at (888) 275-8750. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. 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.

Except for Emergency Services and out-of-area Urgent Care Services, Marketplace Members must receive Covered Services from Participating Providers; otherwise, the services are not covered. Marketplace Members will be one-hundred percent (100%) responsible for payment and the payments will not apply to towards Deductibles or Annual Out-of-Pocket Maximums.

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, self-referral, provider referral, etc. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and/or their authorized representative(s), create an individualized care plan

{00413751;1}

Last Updated: 12/2019

Page 60

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

(ICP). The ICP is documented in the medical record and is updated as conditions, needs and/or health status change. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and need continued care.

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

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

Continuity of Care and Transition of Members

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

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

{00413751;1}

Last Updated: 12/2019

Page 61

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

For additional information regarding continuity of care and transition of Members, please contact Molina at (888) 322-4078.

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:

New Mexico Children, Youth & Families Department

Phone: 1-855-333-SAFE (7233)

Adult Abuse:

New Mexico Aging & Long-Term Services Department

Phone: 1-866-654-3219

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.

Continuity and Coordination of Provider Communication

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

Care Management

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

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

The case manager collaborates with the Member all resources involved in the Member's care to develop an ICP that includes recommended interventions from the Member's interdisciplinary care team (ICT). ICP interventions include links to the appropriate institutional and community resources, to address medical 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 case manager, Providers, and the Member are responsible for implementing the plan of care. Additionally, the case manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources.
- Serves as a coordinator and resource to team members throughout the implementation of the plan and makes revisions to the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-help.

{00413751;1}

Last Updated: 12/2019

Page 63

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the ICM program.

Health Management

Molina's Health Management programs can be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation and weight management. There are also disease-specific health management programs for Asthma and Depression. Molina also offers a Maternity program to support healthy outcomes for pregnant Member and their babies. Refer to "Benefits and Covered Services" section for detailed information regarding these services.

In addition to Asthma and Depression, other programs are offered such as:

- Weight Management – For information about the telephonic Molina Weight Management Program or to enroll members, please contact our Member Assessment Unit.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll Members, please contact our Health Management Unit.
- Maternity Program – For information about Maternity Program or to enroll members, please contact our OB Prenatal service Unit.

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- Maternity Program – For information about Maternity Program or to enroll members, please contact our OB Prenatal service Unit.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at www.MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test.

Case Management (CM)

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

The Molina case managers may be licensed professionals and are educated, trained and experienced in the Care Management process. 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 approval from the Member's PCP. The Molina case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Care Management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program. The case manager works collaboratively with all Members of the integrated care team (ICT), including the PCP, hospital UM staff, discharge planners, specialist Providers, ancillary Providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Preterm infants
- Catastrophic medical conditions (e.g., neoplasm, organ/tissue transplants)
- Chronic illness (e.g., asthma, diabetes, End Stage Renal Disease)
- High-technology home care requiring more than two (2) weeks of treatment
- Member accessing Emergency Department services inappropriately

{00413751;1}

Last Updated: 12/2019

Page 65

Referrals to the ICM program may be made by contacting Molina at:

Toll Free Phone: (866) 891-2320

Toll Free Fax: (800) 642-3691

8. Quality

Maintaining Quality Improvement Processes and Programs

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina Quality department toll free at (800) 377-6564.

The address for mail requests is:

Molina Healthcare of New Mexico, Inc.
Quality Department
400 Tijeras NW, Suite 500
Albuquerque, NM 87102

This Provider Manual contains excerpts from the Molina Quality Improvement Program. For a complete copy of Molina 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 activities to Medical Groups/IPAs. However, Molina requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care and to:

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

{00413751;1}

Last Updated: 12/2019

Page 67

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

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

{00413751;1}

Last Updated: 12/2019

Page 68

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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

Content

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

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical, behavioral 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.
- 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; and,
- A release document for each Member authorizing Molina to release medical information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina for purposes of Quality Improvement;
- The medical record is available to the Superintendent of Insurance 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; and,
- 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

{00413751;1}

Last Updated: 12/2019

Page 70

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

all other applicable Federal and State regulations. This should include, and is not limited to, the following:

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

Additional information on medical records is available from your local Molina Quality department toll free at (800) 377-9594. See also the Compliance section of this Provider Manual for additional information regarding HIPAA.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating 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 PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

Appointment Access

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

Medical Appointment

| Appointment Types | Standard |
|--------------------------|--|
| Routine, asymptomatic | Within thirty (30) calendar days (unless the Member requests a later time) |

{00413751;1}

Last Updated: 12/2019

Page 71

| | |
|------------------------------|--|
| Routine, symptomatic | Within fourteen (14) calendar days (unless the Member requests a later time) |
| Urgent Care | Within twenty-four (24) hours |
| After Hours Care | Twenty-four (24) hours/day; seven (7) day/week availability |
| Specialty Care (High Volume) | Within fourteen (14) calendar days (unless the Member requests a later time) |
| Specialty Care (High Impact) | Within fourteen (14) calendar days (unless the Member requests a later time) |
| Urgent Specialty Care | Within twenty-four (24) hours |

Behavioral Health Appointment

| Appointment Types | Standard |
|------------------------|--|
| Emergency | Immediately |
| Non-Emergency | Within six (6) hours |
| Urgent Care | Within twenty-four (24) hours |
| Routine Care | Within fourteen (14) calendar days |
| Follow-up Routine Care | Within thirty (30) calendar days (unless the Member requests a later time) |

Additional information on appointment access standards is available from your local Molina Quality department toll free (800) 377-9594.

Office Wait Time

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

{00413751;1}

Last Updated: 12/2019

Page 72

After Hours

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

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services department toll free at (888) 322-4078 or TTY/TDD 711;
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and,
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

{00413751;1}

Last Updated: 12/2019

Page 73

handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close his/her panel to new Members, Molina must receive thirty (30) days advance written notice from the Provider.

Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina 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) 377-9594.

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 the following mechanisms:

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

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

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 identified during the compliance/grievance review process 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 visits includes, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of Waiting and Examining Room Space

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

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.

{00413751;1}

Last Updated: 12/2019

Page 75

- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per physician.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR certified employee is available
- Yearly Occupational Safety and Health (OSHA) training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and 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 directives requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. There are three (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

{00413751;1}

Last Updated: 12/2019

Page 76

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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

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

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 Caring Connections website at <http://www.caringinfo.org/stateaddownload> for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

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. 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.

Services to Enrollees Under Twenty-One (21) Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all Enrollees under twenty-one (21) years of age are timely according to required preventive health guidelines. All Enrollees under twenty-one (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 Website](https://www.molinahealthcare.com/providers/common/marketplace/resource/Pages/hlthguide.aspx) (<https://www.molinahealthcare.com/providers/common/marketplace/resource/Pages/hlthguide.aspx>) and referenced in the Benefits and Covered Services section of this Provider Manual.

Well Child/Adolescent Visits

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

- comprehensive health and developmental history;
- nutritional assessment;
- height and weight and growth charting;
- comprehensive unclothed physical examination;
- appropriate immunizations;
- laboratory procedures, including lead blood level assessment appropriate for age and risk factors;
- periodic developmental and behavioral screening;
- vision and hearing tests;
- dental assessment and services;
- health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention).

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

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

Monitoring for Compliance with Standards

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

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. 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

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

Care Management

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

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least

{00413751;1}

Last Updated: 12/2019

Page 79

annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published.

Molina Clinical Practice Guidelines include the following:

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

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, 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 toll free at (800) 377-9594.

Preventive Health Guidelines

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

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

All guidelines are updated with each release by the United States Preventive Task Force (USPSTF) and are approved by the Quality Improvement Committee. On an

{00413751;1}

Last Updated: 12/2019

Page 80

annual basis, Preventive Health Guidelines are distributed to Providers via <https://www.molinahealthcare.com/providers/common/marketplace/resource/Pages/hlthguide.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®)
- Qualified Health Plan (QHP) Enrollee Experience Survey
- Behavioral Health Survey
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives
- Quality Rating System

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 by visiting our website at <https://www.molinahealthcare.com/members/nm/en-US/mem/marketplace/quality/Pages/quality.aspx>.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must

{00413751;1}

Last Updated: 12/2019

Page 81

follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women’s health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina’s clinical Quality Improvement 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.

Qualified Health Plan (QHP) Enrollee Experience Survey

The QHP Enrollee Experience Survey is a consumer experience survey that assesses enrollee experience with QHPs offered through Marketplaces. The QHP Enrollee Survey is fielded nationally by HHS-approved survey vendors using a standardized protocol to facilitate QHP comparison both within and across Marketplaces.

The QHP Enrollee Experience Survey was designed to collect accurate and reliable information from consumers about their experience with the health care they received through Health Insurance Marketplace Qualified Health Plans (QHPs). The survey includes a set of core questions that address key areas of care and service, with some questions grouped to form composites.

QHP Enrollee Survey topics include:

- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Customer Service
- Doctor communication
- Health promotion
- Plan administration
- Prevention
- Shared decision-making
- Specialized services

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, we use to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina’s specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

Quality Rating System

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

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

Quality ratings are calculated for each eligible QHP product using clinical quality and enrollee experience survey data. Based on results, CMS will calculate and produce

{00413751;1}

Last Updated: 12/2019

Page 83

quality performance ratings for each health plan on a one to five (1 to 5) star rating scale.

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

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

What Can Providers Do?

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

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

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

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

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 program also addresses fraud, waste and abuse prevention and detection along with and the education of appropriate employees, vendors, Providers and associates doing business with Molina.

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

Mission Statement

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

{00413751;1}

Last Updated: 12/2019

Page 85

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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.

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

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.

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 Marketplace program.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Marketplace 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 Marketplace 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:

- 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.
- Up coding, 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.

New Mexico Insurance Fraud Act

The New Mexico Superintendent of Insurance investigates insurance fraud. Insurance fraud includes any act or practice connected to an insurance transaction that constitutes a crime under New Mexico's criminal or insurance codes. Any Provider or other person who reasonably believes that an act of insurance fraud will be, is being or has been committed may disclose any information in his/her possession regarding this to the Superintendent or to Molina, if requested for the purpose of detecting, prosecuting or preventing insurance fraud.

{00413751;1}

Last Updated: 12/2019

Page 87

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

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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 Marketplace benefits.
- Conspiracy to defraud the Marketplace.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that he/she does not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

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

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

Molina 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 and Medicaid Services (CMS), Federal CMS guidelines, AMA and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician

{00413751;1}

Last Updated: 12/2019

Page 88

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Fee Schedule Relative File (NPFS), the Medical 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 Healthcare 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.

{00413751;1}

Last Updated: 12/2019

Page 89

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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, 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 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.

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, 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 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

If you suspect 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 twenty-four (24) hours a day, seven (7) days a week, three-hundred-sixty-five (365) days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina 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 New Mexico, Inc.
Attn: Compliance
400 Tijeras NW, Suite 200
Albuquerque, NM 87102

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, Marketplace ID number and any other identifying information.

{00413751;1}

Last Updated: 12/2019

Page 91

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

New Mexico Office of the Superintendent of Insurance
Insurance Fraud Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689

Toll Free Phone: (877) 807-4010

Website: <https://www.osi.state.nm.us/FraudBureau/InsuranceFraud.aspx>

Online Fraud Reporting Form: <https://www.osi.state.nm.us/FraudBureau/stopfraud.aspx>

New Mexico Attorney General
P.O. Drawer 1508
Santa Fe, NM 87504-1508

Phone: (505) 827-6000

Fax: (505) 827-5826

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.

{00413751;1}

Last Updated: 12/2019

Page 92

- Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Applicable Laws

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

1. Federal Laws and Regulations

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

2. State Medical Privacy Laws and Regulations.

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

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity¹. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation,

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

utilization review activities, such as preauthorization of services, inpatient review, and retrospective review of “services².”

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

- Quality improvement
- Disease management
- Case management and care coordination
- Training Programs
- Accreditation, licensing, and credentialing

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality Improvement.

Confidentiality of Substance Use Disorder Patient Records

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

Inadvertent Disclosures of PHI

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

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

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

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

1. **Notice of Privacy Practices**

Providers that are covered under HIPAA and that have a direct treatment relationship with the patient must provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient must 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, except for a request not to report or disclose their information to health insurers if the Patient has paid for the services in full.

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 their information that is maintained in a designated record set. A Provider may deny such a request if the

{00413751;1}

Last Updated: 12/2019

Page 95

information: (i) was not created by the covered entity, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment; (ii) is not part of the designated record set; (iii) would not be available for inspection under applicable regulations, or (iv) is accurate and complete.

6. Request Accounting of PHI Disclosures

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

HIPAA Security

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

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

HIPAA Transactions and Code Sets

Molina requires the use of electronic transactions to streamline health care administrative activities. Molina encourages Providers 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 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. And then 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

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and Grievance

{00413751;1}

Last Updated: 12/2019

Page 97

- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

Member Authorization to Release Protected Health Information

English Form:

<https://www.molinahealthcare.com/providers/nm/marketplace/forms/PDF/authorization-for-phi.pdf>

Spanish Form:

<https://www.molinahealthcare.com/providers/nm/marketplace/forms/PDF/authorization-for-phi-spanish.pdf>

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:

- 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

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and Federal Provider billing guidelines. Providers are encouraged to utilize electronic billing through 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 09824.

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.

Manual Claims Submission

Providers may submit claims manually via U.S. mail or hand delivery. Providers may obtain standard forms for submitting claims or for coding changes from Molina.

Manual Claims Mailing Address:

Molina Healthcare of New Mexico, Inc.
Po Box 22801

{00413751;1}

Last Updated: 12/2019

Page 99

Long Beach, CA 90801

Manual Claims Hand Delivery Address:

Molina Healthcare of New Mexico, Inc.
400 Tijeras Ave. NW, #200
Albuquerque, NM 87102

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.

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 Federal 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 (or written signature for manual claims).
- 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.

Electronic Claims Submission

Molina 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 09824

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 previously submitted clearinghouse claims).
- 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.
- Print claim reports.

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.

{00413751;1}

Last Updated: 12/2019

Page 101

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 toll free at (866) 409-2935 or email us at EDI.Claims@MolinaHealthcare.com for additional support.

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

For Members enrolled in a Molina Marketplace plan, Molina and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina Marketplace will pay Claims for Covered Services, however if TPL/COB is determined post payment, Molina Marketplace will attempt to recover any Overpayments.

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 ninety (90) calendar days after the discharge for inpatient services or the Date of Service for outpatient services.

If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within one (1) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

{00413751;1}

Last Updated: 12/2019

Page 102

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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 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). If a professional organization has a more stringent/restrictive standard than a Federal MUE, the professional organization standard may be used.
 - Medicare National Coverage Determinations (NCDs).
 - 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.
- 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 Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

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.

{00413751;1}

Last Updated: 12/2019

Page 104

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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.

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

{00413751;1}

Last Updated: 12/2019

Page 105

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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

{00413751;1}

Last Updated: 12/2019

Page 106

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

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

Corrected Claims

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

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

EDI (Clearinghouse) Submission

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
 - "1"-ORIGINAL (initial claim)
 - "7"-REPLACEMENT (replacement of prior claim)
 - "8"-VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

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

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within thirty (30) days after receipt of Clean Electronic Claims and forty-five (45) days for Clean manual claims.

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

{00413751;1}

Last Updated: 12/2019

Page 107

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 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 will make any retroactive adjustments for overpayments no later than eighteen (18) months after the overpayment was made, except in cases of health care professional miscoding, claim submission error, suspected fraud and abuse, or where retroactive adjustments are required by Federal or State agencies.

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

If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider. Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Claim Disputes/Reconsiderations

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

- Any documentation to support the reconsideration request and all supporting documentation (if applicable) must accompany the reconsideration request.

{00413751;1}

Last Updated: 12/2019

Page 108

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

- The Claim number clearly marked on all supporting documents

PRR Forms must be submitted via fax (do not mail):

Molina Healthcare of New Mexico, Inc.
Attention: Provider Reconsideration Review Request
Toll free fax: (855) 378-3642

The Provider will be notified of Molina's decision in writing within thirty (30) calendar days of receipt of the PRR request.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits beyond applicable copayment, deductibles or coinsurance. 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 (except for applicable co-pay/coinsurance) or bill the appropriate responsible party.
- 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 (not applicable to emergency services):
 - 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 HEDIS® reporting.

{00413751;1}

Last Updated: 12/2019

Page 109

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Encounter data must be submitted at least once per month, and within ninety (90) days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

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 Molina's 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.

11. Complaints, Grievance and Appeals Process

Provider Complaints and Grievances

Providers have the right to present concerns regarding the operation of the plan by Molina, termination from the plan, timeliness of credentialing decisions, concerns regarding the quality of and access to health care services, the choice of health care Providers and the adequacy of the Molina network to the Molina Provider grievance committee responsible for the substantive area raised by the concern.

Contact Information for Provider Grievances and Appeals

Molina Healthcare of New Mexico
PO Box 3887
Albuquerque, NM, 87190

855-322-4078

Provider Grievances

1. Provider Grievances are submitted orally or in writing.
2. A Provider may file a grievance. A Provider may present his/her concerns regarding the operation of the plan, termination from the plan, timeliness of credentialing decisions, concerns regarding quality of and access to health care services, the choice of health care Providers and the adequacy of the Molina network to the Molina Provider Grievance Committee responsible for the substantive area addressed by the concern.
3. Molina's Provider Grievance Committee. Provider concerns will be addressed by a committee of Molina staff members. The Provider Grievance Committee will consist of:
 - Chairperson;
 - Supervisor/Manager/Director of Network Management;
 - Supervisor/Manager/Director of Provider Appeals and Grievances;
 - Supervisor/Manager/Director of Quality Improvement;
 - Supervisor/Manager/Director of Health Care Services; and,
 - Medical Director or Chief Medical Officer (acting in the capacity of a consultant if the concern involves a clinical or quality of care issue) – ad hoc member.
4. The decision of the Provider Grievance Committee will be communicated to the Provider, in writing within twenty (20) days after the committee has obtained all of the information concerning the Provider's grievance.

{00413751;1}

Last Updated: 12/2019

Page 111

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual
Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

5. A recap of all Provider grievances will be provided to Molina's governing body as part of the monthly Senior Leadership Team meeting agenda.
6. Information regarding Provider grievance procedures is included in Provider contracts, the Provider Manual and remittance advice statements.
7. Registering and responding to Provider grievances is done by a member of the Provider Appeals and Grievances department. The activities involved in registering and responding to Provider grievances or appeals includes the following:
 - Documentation of the issue and resolution in the QNXT system;
 - Documentation of the issue and resolution in the Appeals and Grievances (AnG) database;
 - Coordinating Provider grievance reviews with the Molina Provider Grievance Committee; and,
 - Notification to the Provider of the grievance review results in writing within twenty (20) days of receipt of all information concerning the grievance.
8. The Provider Appeals and Grievances department coordinates relaying Provider grievance information to internal quality improvement committees.
9. Written notifications to the Provider of grievance review determination decisions will include the following elements:
 - The names and titles of the reviewers;
 - A statement of the reviewer's understanding of the nature of the grievance and all pertinent facts;
 - Reference to the evidence or documentation considered by the reviewer(s) in making the decision as applicable; and,
 - An explanation of the rationale for the reviewer's decision.
10. Molina will provide a written explanation to the Provider for any proposed termination and shall deliver reasonable advance written notice to the Provider prior to the proposed effective date of the termination. Such notice shall be delivered if the termination is for cause as described in 13.10.16.9 NMAC, Subsection A, if the termination is at the convenience of Molina, if the termination is by virtue of a fixed termination date in the Provider contract or if Molina does not intend to offer renewal of the Provider contract.
11. Reasonable advance written notice is a minimum of thirty (30) days, except when the quality of care provided to enrollees is the basis for the termination.
12. When the quality of care provided to enrollees is the basis for the termination and Molina has a good faith and reasonable belief that further care by the Provider would result in imminent and significant harm to enrollees, Molina is not required to provide advance written notice, but shall follow the expedited fair hearing process pursuant to 13.10.16.9(A)(1)(c) NMAC.
13. Molina has developed, adopted and implemented a fair hearing process so that a Provider may dispute whether Molina has adequate cause to terminate a Provider's participation with the plan if the Provider's relationship with Molina is, in fact, being terminated for cause. A Provider may present their case to the

{00413751;1}

Last Updated: 12/2019

Page 112

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Provider Grievance Committee which consists of various Molina staff Members (see item #3).

14. A Provider who is being terminated for cause will be afforded access to the Molina fair hearing process. Through this process, the Provider will have the following rights:
 - The right to appear in person before the fair hearing committee appointed by Molina pursuant to 13.10.16.9(A)(1)(a) NMAC prior to the proposed termination date;
 - The right to present their case to the fair hearing committee;
 - The right to submit supporting material both before and at the fair hearing;
 - The right to ask questions of any representative of Molina who attends the hearing;
 - The right to be represented by an attorney or by any other person of the Provider's choosing; and,
 - The right to an expedited hearing in those instances where Molina has not provided advance written notice of termination to the Provider because Molina has a good faith and reasonable belief that further care by the Provider would result in imminent and significant harm to enrollees.
15. A written fair hearing decision will be issued to the Provider within twenty (20) days after the fair hearing. Following an expedited hearing, a written decision will be forwarded to the Provider as soon as the decision is issued, but no later than three (3) business days.

To file a complaint with the New Mexico Office of Superintendent of Insurance (OSI)

To file a complaint with the OSI, use the form found on the OSI website at <https://www.osi.state.nm.us/>.

For grievances concerning Molina's operations or Provider terminations, follow the procedure for 13.10.16.10 NMAC.

For grievances concerning credentialing and payment dispute resolution, follow the procedures for 13.10.28.13(B) NMAC.

Provider Credentialing Grievances

The purpose of this section is to ensure that Providers receive prompt payment from Molina for clean claims and interest on unpaid claims.

Molina has established a process for resolving payment-related credentialing disputes:

- The Provider must contact Molina in writing to determine the status of a claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered to be a clean claim.
- Molina will respond in writing to a Provider's inquiry regarding the status of an unpaid claim within fifteen (15) days of receiving the inquiry.
- Molina's response will explain its failure or refusal to pay, and the expected date of payment if payment is pending.

After Approval of Credentialing

1. The Practitioner's contract effective date will be determined by NM&O. Contracted Providers will receive a contract effective date no sooner than the beginning of the first of the month following approval by the credentialing committee. Based on access and availability needs, the contract may have an effective date either immediately upon approval of credentialing; or,
2. The Associate Vice President/Director of NM&O will determine if the effective date of the contract is to be prior to the Credentialing Committee approval date.

If Network Participation due to Credentialing is Denied

The Credentialing Committee may determine that the Practitioner should not be approved for participation in the Molina network. The Credentialing Committee may then vote to deny the Practitioner. The Practitioner will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) days of the Committee's decision, the Practitioner is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

1. For Providers denied credentialing approval, payment will revert to out-of-network usual, customary, and reasonable rate effective to the date of denial except as otherwise provided by Law; and,
2. Services rendered after the denial date, with the exception of emergency situations, will require prior authorization from the Health Care Services (HCS) department and will be based on access and availability needs.

Non-Participating Providers

- The Network Management and Operations department is responsible for recruiting and obtaining an executed Provider or Hospital Services Agreement and other appropriate documentation in order to configure the financial terms within Molina's systems.

- For Providers who will not execute a Molina Provider or Hospital Agreement, a standard non-participating contract may be configured within the claims system for reimbursement at the usual, customary, and reasonable rate or specific reimbursement terms may be negotiated on a case-by-case basis and configured accordingly.

Addendum A - State Specific Reimbursement Requirements, Claims Payment, and Interest Calculations

Reimbursement by Molina upon delay in credentialing process (Pursuant to NMAC 13.10.28.12)

Terms for reimbursement - Molina shall reimburse a Provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services, provided that:

- the date of service is more than forty-five (45) days after the date the Provider requested credentialing from Molina and either the Provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access by Molina, including submission of any supporting documentation that Molina requested in writing during the initial ten (10) day review period;
- Molina has approved or has failed to approve or deny the applicant's completed uniform credentialing application within the timeframe established pursuant to Subsection C of 13.10.28.11 NMAC;
- the Provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a Provider licensed in another State; and,
- the Provider has professional liability insurance or is covered under the Medical Malpractice Act.

Sole Practitioner - A Provider who, at the time services were rendered has been approved by Molina for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was not in a practice or group that has contracted with Molina to provide services at specified rates of reimbursement, shall be paid by Molina in accordance with the carrier's standard reimbursement rate or at an agreed upon rate.

Provider group reimbursement - A Provider who, at the time services were rendered, has been approved by Molina for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was in a provider group that has contracted with Molina to provide services at specified rates of reimbursement, shall be paid by Molina in accordance with the terms of the Provider group contract.

{00413751;1}

Last Updated: 12/2019

Page 115

Reimbursement period - Molina shall reimburse a Provider pursuant to Subsections A, B, and C of 13.10.28.12 NMAC until the earlier of the following occurs:

- Molina denies the Provider's credentialing application;
- Molina approves the Provider's credentialing application and the provider and Molina enter a contract to replace a previously agreed upon rate, or,
- the passage of three (3) years from the date the insurer received the Provider's completed uniform credentialing application.

Payments of Claims, Overdue Claims and Calculation of Interest (Pursuant to NMAC 13.10.28.9)

Pending claims

- Questionable liability and special treatment claims.
 - If, upon receipt of a claim, Molina is unable to determine liability for, or otherwise refuses to pay a claim or a portion of a claim of an eligible Provider within the time specified in Subsection A of 13.10.28.9 NMAC, Molina shall make a good faith effort to notify the eligible Provider electronically, in writing, or by another method, as agreed between Molina and Provider, within thirty (30) days of the date of receipt of the claim if submitted electronically and within forty-five (45) days of the date of receipt of the claim if submitted manually.
 - If, upon receipt of a claim, Molina determines that a claim or a portion of a claim requires special treatment due to particular or unusual circumstances that will delay payment beyond the time specified in Subsection A of 13.10.28.9 NMAC, Molina shall make a good faith effort to notify the eligible Provider electronically, in writing, or by another method, as agreed between Molina and Provider, within thirty (30) days of the date of receipt of the claim if submitted electronically and within forty-five (45) days of the date of receipt of the claim if submitted manually.
- Notification of pending claims. The notification required by Subsection C of 13.10.28.9 NMAC, shall:
 - specify the reason(s) why Molina is refusing to pay the claim, has determined it is not liable for the claim, or shall specify what information is required to determine liability for the claim;
 - clearly indicate if only certain charges associated with a claim are contested; and
 - be repeated by Molina at least monthly until the matter is resolved.
- Uncontested portion of pending claims. The timely payment requirement described in Section A of 13.10.28.9 NMAC applies to any uncontested portion of a contested claim.
- Liability resolved. The date on which liability or special treatment issues are resolved for a pending claim is the date that the claim becomes a clean claim and shall initiate the timely payment requirement described in Subsection A of 13.10.28.9 NMAC.

Overdue payments, calculation of interest

- When payment is not made by Molina to the Provider within the time specified in Subsection A of 13.10.28.9 NMAC and there is no question of liability or special treatment as described in Subsection C of 13.10.28.9 NMAC or questions of liability or special treatment have been resolved, interest shall be calculated and paid to the Provider, on the unpaid portion of the claim as follows:
 - For any full or partial month, beginning on the 31st day after the claim has been submitted electronically and on the 46th day for claims submitted manually, Molina shall calculate and pay interest in the amount of one and one-half percent for each full or partial month. For purposes of this section, any thirty (30) day period is the equivalent of one month, excepting that a calendar year shall only be equal to twelve (12) months; and,
 - Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. Molina shall not be required to pay any interest calculated to be less than two dollars (\$2.00). The interest shall be paid within thirty (30) days of the payment of the claim. Interest can be paid on the same check or electronic transfer as the claim payment or on a separate check or electronic transfer. If Molina combines interest payments for more than one late clean claim, the check or electronic transfer shall include information identifying each claim covered by the check or electronic transfer and the specific amount of interest being paid for each claim.
- When a claim that involves a question of liability or special treatment is ultimately resolved in favor of the Provider and is not paid within thirty (30) or forty-five (45) days of becoming an electronic or manual clean claim, respectively, Molina shall pay all of the interest due on the unpaid claim, to be calculated as described in Paragraph (1) of Subsection D of 13.10.28.9 NMAC.

Member Grievances

Molina Members have the right to file a grievance and/or appeal if there is a problem with medical care or Molina's services. Molina's grievance and appeal procedures follow the Summary of Health Insurance Grievance Procedures found at <https://www.molinahealthcare.com/members/nm/en-US/mem/marketplace/quality/Pages/gna.aspx>.

The complete regulations for grievances and appeals are located at New Mexico Administrative Code §13.10.17. The text of these regulations can be found at: <http://164.64.110.134/parts/title13/13.010.0017.html>.

The contact information for Molina's Grievance and Appeals department is:

Molina Healthcare of New Mexico
Grievance and Appeals Unit

{00413751;1}

Last Updated: 12/2019

Page 117

400 Tijeras Ave. NW, Suite 200
Albuquerque, NM 87102

Fax #: (505) 342-0583

E-Mail: Marketplace.Grievances@MolinaHealthCare.Com

No person shall be subject to retaliatory action by Molina for any reason related to a grievance.

12. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. 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.

Type 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)

{00413751;1}

Last Updated: 12/2019

Page 119

- 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
- 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 to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

{00413751;1}

Last Updated: 12/2019

Page 120

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

- **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 one-hundred-eighty (180) 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** – Providers must only be credentialed in the specialty in which they have adequate education and training. Providers 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 in their designated specialty.
- **Residency Training** – Provider 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 three (3)-year residency or is not board certified, the podiatrist must have five (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 five (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 five (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 five (5)-years 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 six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, 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 body³. 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

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.

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.
- **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.

{00413751;1}

Last Updated: 12/2019

Page 124

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

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- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

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.

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 ten (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, 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 Practitioner’s, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within ten (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 seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The 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.

Providers' 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 two (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

A letter is sent to every Provider with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within forty-five (45) calendar days of receipt of a Provider's request for credentialing or a Provider's completed uniform credentialing form, whichever is earlier. This will allow for time to obtain the credentialing form in electronic format, request and obtain third party verification, and make and notify the Provider of the decision. The forty-five (45) day period will not commence until the applicant provides all requested information or documentation. Copies of the letters are filed in the Provider's credentials files.

Recredentialing

Molina recredentials every Practitioner at least every thirty-six (36) months.

Molina will notify a Provider at least one-hundred-twenty (120) days in advance of all items necessary to complete recredentialing. Molina will complete the recredentialing process within forty-five (45) days of receipt of the Provider's complete recredentialing application and all supporting documents.

{00413751;1}

Last Updated: 12/2019

Page 126

In general, once a credentialing application has been approved, re-credentialing verification may not be required more frequently than every three (3) years. If Molina has approved an application provisionally, then re-credentialing may be required annually or at the conclusion of a shorter period if required by Molina's accreditation organization and approved by OSI. Nothing in this section shall be construed to require Molina to credential or provisionally credential any Provider. Nothing in this section shall be construed to prevent Molina from terminating its participation agreement with a Provider for cause at any time; regardless of time remaining before re-credentialing is due.

Except as may otherwise be required by Molina's accreditation organization, Molina may not require a participating Provider to be re-credentialed based on: (a) a change in the provider's Federal Tax Identification number; (b) a change in the Federal Tax Identification number of a Provider's employer; or (c) a change in the Provider's employer, if the new employer: (i) is a participating Provider; or (ii) also employs other participating Providers. Molina may require a participating Provider or the Provider's employer to give written notice of a change in the Provider's or the Provider's employer's Federal Tax Identification number not less than forty-five (45) calendar days before the effective date of the change.

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

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against

{00413751;1}

Last Updated: 12/2019

Page 127

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

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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 and 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.

Reimbursement upon Delay in the Credentialing Process

Molina shall reimburse a Provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services, provided that:

{00413751;1}

Last Updated: 12/2019

Page 128

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

- The date of service is more than forty-five (45) calendar days after the date the Provider requested credentialing from Molina and either the Provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access by Molina, including submission of any supporting documentation that the health carrier requested in writing during the initial ten (10)-day review period;
- Molina has approved, or has failed to approve or deny the applicant's completed uniform credentialing application within the timeframes established herein;
- The Provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-State licensing and regulatory entity for a Provider licensed in another State; and,
- The Provider has professional liability insurance or is covered under the Medical Malpractice Act.

A Provider who, at the time services were rendered has been approved by Molina for credentialing or who has been awaiting a credentialing decision as provided herein and was not in a practice or group that has contracted with Molina to provide services at specified rates of reimbursement, shall be paid by Molina in accordance with its policies as stated herein or an agreed upon rate. A Provider who, at the time services were rendered, has been approved by a health carrier for credentialing or who has been awaiting a credentialing decision as provided herein and was in a Provider group that has contracted with the health carrier to provide services at specified rates of reimbursement, shall be paid by the carrier in accordance with the terms of the Provider group contract.

Molina shall reimburse a Provider under the terms of this subsection until the earlier of the following occurs: (1) Molina denies the Provider's credentialing application; (2) Molina approves the Provider's credentialing application and the Provider and Molina enter a contract to replace a previously agreed upon rate, or the passage of three (3) years from the date Molina received the Provider's completed uniform credentialing application.

Credentialing and Payment Dispute Resolution

If a Provider disputes Molina's payment of claims when a credentialing decision has been delayed beyond the timeframes provided herein, the Provider may initiate an internal grievance. To initiate the grievance, the Provider shall contact Molina's Provider Grievances and Appeals department in writing to determine the status of the claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered by Molina to be a clean claim. Molina shall respond in writing to a Provider's inquiry regarding the status of an unpaid claim within fifteen (15) days of receiving the inquiry and shall explain its failure or refusal to pay, and the expected date of payment if payment is pending.

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If Molina fails to respond or the Provider believes that payment is being denied, delayed, or calculated in error and the matter has not been successfully resolved at the internal level within forty-five (45) days, then the Provider may file a complaint, either individually or in batches, with the Superintendent using the form found on the OSI website (https://www.osi.state.nm.us/docs/OSI-Provider_complaint_form.pdf).

Complaints filed with the superintendent shall contain the following information: (a) the Provider's name, identification number, address, daytime telephone number and the claim number; (b) the date that the Provider's request for credentialing was complete; (c) the name and address Molina; (d) the name of the patient and employer (if known); (e) the date(s) of service and the date(s) the claims were submitted to Molina; (f) relevant correspondence between the Provider and Molina, including requests for additional information from Molina; (g) additional information which the Provider believes would be of assistance in the superintendent's review; and (h) only those excerpts from Provider contracts that are minimally necessary to resolve the dispute shall be submitted to the superintendent, who shall maintain the confidentiality of such excerpts to the fullest extent allowed by applicable Law.

The complaining Provider shall furnish Molina with a complete copy of the complaint and submitted documentation concurrently with the Provider's submission to the superintendent. Molina will have ten (10) business days after the Provider's submission to resolve the matter or to submit additional information that it believes would be of assistance to the superintendent's review.

The superintendent will review the matter, based on documents and other materials that are submitted by the Provider and Molina for this purpose. The superintendent may issue an order resolving the dispute, with or without a hearing. If the superintendent determines, at their sole discretion, that a hearing is necessary, then the Provider and Molina may appear and may elect to be represented by counsel at the hearing. The superintendent may designate one or more persons to act as hearing officer. The hearing officer shall prepare a recommendation for the superintendent's review.

The superintendent's decision will be issued within thirty (30) days of receiving a payment complaint if no hearing is required or within thirty (30) days of the hearing, if a hearing is held.

13. Delegation

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

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

Delegation Criteria

Credentialing

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

- Pass Molina's credentialing pre-assessment, 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 and SAM exclusion lists a minimum of every thirty (30) days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.

Note: If the Provider is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depend on the type of Certification or Accreditation the entity has but will always include evaluation of applicable State requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA© accredited or certified in Credentialing functions, or demonstrate and

{00413751;1}

Last Updated: 12/2019

Page 131

ability to meet all Health Plan, NCQA®, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

An entity may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through their Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the entity's ability to meet Molina, State and Federal requirements for delegation.

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 Contract Manager.

CMS Preclusion List

All subcontractors delegated for Credentialing and/or Claims Administration must review their practitioner network against the CMS Preclusion list. The CMS Preclusion list will be provided to the subcontractor on a monthly basis by Molina. Within five (5) business days of receipt, the subcontractor must review the list and identify any practitioners with a new preclusion since the last publication date. Within fifteen (15) calendar days of receipt of the list, the subcontractor must notify Molina of any identified practitioner(s), including a report of all Molina claims paid to the provider in the previous twelve (12) months. Depending on delegated expectations, subcontractors may also be responsible for sending the necessary Member notification at least sixty (60) calendar days prior to the Preclusion effective date, informing the Member of the need to select a new practitioner.

Note: Member notification responsibilities depend on the functions delegated and the services provided. Not all subcontractors are responsible for this piece, and in some cases, are required to send the appropriate information to Molina so that Molina can notify impacted Members. If there are questions about subcontractor responsibilities related to Member notification of precluded providers, please contact your Molina Delegation Oversight contact.

14. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide Members with high quality, cost effective drug therapy. Molina works with 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) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is 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.

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.

{00413751;1}

Last Updated: 12/2019

Page 133

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.

Non-formulary Medications

Non-formulary 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 the Uniform Prior Authorization form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity.

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, PA must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six (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 Molina Marketplace are 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 completed 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 Uniform Prior

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Authorization form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication PA Request form to Molina at (866) 472-4578. A blank Medication PA Request form may be obtained by accessing www.MolinaHealthcare.com or by calling (855) 322-4078.

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© 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, CVS Caremark Specialty Pharmacy, 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.

15. Risk Adjustment Management Program

What is Risk Adjustment?

Risk Adjustment is a process to 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.

Why is Risk Adjustment Important?

- Allows Molina to focus on quality and efficiency.
- Enables Molina to recognize and address current and potential health conditions early.
- Identifies Members for Case Management referral.
- Ensures accurate payment for the acuity levels of our Members.
- Most importantly, Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to Molina Members.

Your Role as a Provider

As a Provider your documentation in a Member's medical record is critical to a Member's quality of care.

For a complete and accurate medical record, all Provider documentation must:

- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only submit codes for diagnoses confirmed during a face to face visit with the Member.
- Contain a treatment plan.
- Be clear and concise.
- Contain the Member's name and date of service.
- Have the Physician's 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 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,

{00413751;1}

Last Updated: 12/2019

Page 137

Molina Healthcare of New Mexico, Inc. Marketplace Provider Manual

Any reference to Molina Healthcare Members means Molina Healthcare Marketplace Members.

Providers will be required to provide medical records 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