PROVIDER RESPONSIBILITIES

This section describes Molina Healthcare's established standards on access to care, office sites, medical record documentation, Member confidentiality, and Member marketing information for participating Providers. In applying the standards listed below, participating Providers have agreed they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits in compliance with the Code of Federal Regulations Title 42 CFR 438.100. 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. If PCPs choose to close their panel to new Members, Molina Healthcare must receive 30 days advance notice from the Provider.

ACCESS TO CARE STANDARDS

Molina Healthcare is committed to providing timely access to care for all Members in a safe and healthy environment. Molina Healthcare will ensure Providers offer hours of operation no less than offered to commercial enrollees. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available 24 hours a day, seven days a week to Members. This access may be by telephone. Appointment and waiting time standards are shown below. Any Member assigned to you on your monthly eligibility list is considered your patient.

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

PCP Role in Assessing and Referring Members for Mental Health and Chemical Dependency Services

It is the primary care provider's (PCP) responsibility to assess if a member has any symptoms of a mental health or chemical dependency condition. If the results of the assessment are positive for mental health or chemical dependency issues, the PCP is responsible for referring the member to the appropriate mental health or chemical dependency services. In addition, it is the PCP's responsibility to support and encourage the member toward recovery and educate the member on the benefits of treating these conditions as well as the risks. Information on the principles of recovery and provider strategies to support recovery can be found on our Provider Website under page http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf.

Referral for Mental Health Services
The mental health benefit for Washington Medicaid beneficiaries is a two-tiered benefit. Outpatient mental health services for mild to moderate mental health conditions including psychotherapy, psychological testing, and medication management are covered under the managed care benefit. Members may also self-refer for mental health services. Please see the Molina Provider Website, or contact our Molina Member Services, for a list of participating mental health providers.

More intensive mental health services for members with more severe, chronic mental health conditions, including inpatient mental health, day treatment, and intensive case management services, are provided by the Regional Support Networks (RSNs) for members who meet Access to Care Standards. The RSNs maintain a crisis/access line for members to call for services. The RSNs contract with community mental health agencies and inpatient psychiatric facilities to deliver services. The Access to Care Standards http://www.dhs.state.ia.us/docs/RSNAccesstoCareStandards_8-19-11.pdf can be located on our Provider Website, as well as information on how to refer to the RSNs and a list of RSN contracted providers http://www.dshs.wa.gov/dbhr/rsn.shtml#dbhr.

If you are not sure where to refer a member you may always refer to a Molina provider for an initial evaluation. The Molina case management team will identify members who may meet Access to Care Standards and coordinate a referral to the appropriate RSN. Additional information on Medicaid Mental Health services is included in the Health Care Authority Mental Health Provider Guide http://www.hca.wa.gov/medicaid/billing/Pages/mental_health.aspx.

Referral for Chemical Dependency Services
All Medicaid Chemical Dependency treatment services, with the exception of medical detox in a hospital setting, are provided fee-for-service for Medicaid beneficiaries. Services are delivered by state-licensed chemical dependency providers. Information on how to refer a member for Chemical Dependency services can be found at the Alcohol and Drug Abuse Services and Information http://www.dshs.wa.gov/dbhr/da_information.shtml link on our Provider Website.

SITE AND MEDICAL RECORD-KEEPING PRACTICE REVIEWS

Molina Healthcare of Washington, Inc. (Molina) has a process to ensure that the offices of all practitioners meet its office-site and medical record keeping practices standards. Molina assesses the quality, safety and accessibility of office sites where care is delivered. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines outlined below and the thresholds for acceptable performance against the criteria. This includes an assessment of:

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

Adequacy of medical record-keeping practices

During the site-visit, Molina discusses office documentation practices with the practitioner or practitioner's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and include how the practice ensures confidentiality of records.

Molina assesses one medical/treatment records for orderliness of record and documentation practices. To ensure member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Site Review Nurse (SRN)

A registered nurse with training and experience in quality improvement and ambulatory care evaluates the practitioner's office environment including medical record keeping practices using Molina-approved guidelines and audit tools.

OFFICE SITE REVIEW GUIDELINES AND COMPLIANCE STANDARDS

Practitioner office sites must demonstrate an overall 80% compliance with the Office Site Review Guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Review Nurse to ensure correction of the deficiency.

Facility

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

Access

Standards for appointment scheduling include:

- Next available date for preventive care appointment is < = 30 calendar days

- Next available date for routine primary care appointment is < = 10 calendar days
- Next available time for urgent appointment is within 48 hours
- Standard wait time to be seen for a scheduled appointment is less than 30 minutes.

Safety

- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.

Administration & Confidentiality

- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectibles and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

MEDICAL RECORD KEEPING PRACTICE GUIDELINES AND COMPLIANCE STANDARDS

Practitioner medical record keeping practices must demonstrate an overall 80% compliance with the Medical Record Keeping Practice Guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Review Nurse to ensure correction of the deficiency.

- Each patient has a separate medical record. File markers are legible. Records are stored away from patient areas and preferably locked. Record is available at each patient visit. Archived records are available within 24-hours.
- Pages are securely attached in the medical record. Computer users have individual passwords.

- Medical records are organized by dividers or color-coding when the thickness of the record dictates.
- A chronic problem list is included in the record for all adults and children.
- Allergies (and the lack of allergies) are prominently displayed at the front of the record.
- A complete health history questionnaire or H&P is part of the record.
- Health Maintenance forms includes dates of preventive services.
- A medication sheet is included for chronic medications.
- Advance Directives discussions are documented for those 18 years and older.
- Record keeping is monitored for Quality Improvement and HIPAA compliance.

Within 30 calendar days of the review, a copy of the site review report, the medical record keeping practices report and a letter will be sent to the medical group notifying them of their results.

Improvement Plans/Corrective Action Plans

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

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

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

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

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

MEDICAL RECORD GUIDELINES AND COMPLIANCE STANDARDS

Molina Healthcare of Washington, Inc. (MHW) establishes medical record standard to facilitate communication, coordination and continuity of care and to promote efficient and effective treatment. MHW requires medical records to be maintained in a manner that is current, detailed, organized and permits effective, confidential patient care and quality review. MHW has a process to assess and improve, as needed, the quality of medical record keeping.

At the time of recredentialing, MHW conducts a medical record review of Primary Care Practitioners (PCPs). Guidelines are used that have been adopted by MHW and reviewed and approved by the Credentialing Committee The Credentialing Committee considers medical record review reports with other criteria and information about the practitioner when making credentialing determinations.

When practitioners practice in a group model, the medical record review is conducted for the medical group as a whole, with a random selection of records reviewed from practitioners practicing at that location. A medical record review is conducted at the main location where the practitioner sees MHW members unless the location has fewer than 50 MHW members assigned. Once the PCP medical group has achieved compliance with the medical record review, they do not need to be routinely reviewed again.

Practitioners who are joining a contracted PCP medical group that has been reviewed and found to be in compliance with MHW's medical record review guidelines will not require another review. A copy of the medical group's medical record review report will be filed in the practitioners credentials file and reviewed by the Credentialing Committee as part of the credentialing process.

Medical Records are reviewed to assure the following is reflected:

All services provided directly by a PCP

All ancillary services and diagnostic tests ordered by a practitioner

All diagnostic and therapeutic services for which a member was referred by a practitioner, such as:

- Home health nursing reports
- Specialty physician reports
- Hospital discharge reports
- Physical therapy reports

Confidentiality of Medical Records

MHW members have the right to full consideration of their privacy concerning their medical care. They are also entitled to confidential treatment of all Member communications and records. Case discussion, consultations, examination and treatments are confidential and should be conducted with discretion. Written authorization from the Member or his/her authorized legal

representative must be obtained before medical records are released to anyone not directly connected with his/her care, except as permitted or required by law.

Confidential Information is defined as any form of data, including but not limited to data that can directly or indirectly identify individual Members by character, conduct, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Conversations, whether in a formal or informal setting, e-mail, faxes and letters are also potential sources of Confidential Member Information.

All participating providers must implement and maintain an office procedure that will guard against disclosure of any confidential information to unauthorized persons. The office staff must receive periodic training in confidentiality of member information. This procedure should include:

- Written authorization obtained from the Member or his/her legal representative before medical records are made available to anyone not directly connected with his/her care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
- Only the portion of the medical record specified in the authorization should be made available to the requester and should be separated from the remainder of the Member's medical records.

Site Review Nurse (SRN)

A registered nurse with training and experience in quality improvement and ambulatory care evaluates the practitioner's medical records using MHW approved guidelines and audit tools.

Compliance Standards

Practitioners must demonstrate an overall 80% compliance with the medical record documentation guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Review Nurse to ensure correction of the deficiency. A medical record review survey form is completed at the time of each visit. This form includes the Medical Record Documentation Guidelines outlined below and the thresholds for acceptable performance against these criteria. Medical records are evaluated for the following:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information

In addition, practitioners must achieve 80% compliance in each of the following areas as noted in the guidelines with an asterisk.

- Health history
- Problem Lists
- Medication allergies and adverse reactions
- Diagnoses consistent with findings
- Appropriate treatment
- Plans for future treatment

MEDICAL RECORD DOCUMENTATION GUIDELINES

Practitioners must demonstrate an overall 80% compliance with the medical record documentation guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Review Nurse to ensure correction of the deficiency. 80% compliance required in areas marked with an asterisk.

Medical Record Documentation Includes:

- *****Significant illnesses and medical conditions are indicated on the problem list. If the patient has no known chronic problems, this is appropriately noted in the record.
- *****Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies, this is appropriately noted in the record.
- *****Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children (8 and younger), past medical history related to prenatal care, birth, operations and childhood illnesses.
- *****A working diagnosis is recorded with the clinical findings. SOAP charting format is recommended, but not mandatory when progress notes are written.
- *****Treatment plans are consistent with diagnoses.
- *****There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Patient name and identifying number is on each page of the record.
- The registration form or computer printout contains address, home and work phone numbers, employer and marital status. An emergency contact should also be designated.
- All staff and provider notes are signed with initials or first initial, last name and title.
- All entries are dated.
- The record is legible to someone in the office other than the provider. Dictation is preferred.
- There is an appropriate notation concerning tobacco exposure for children of all ages and the use of alcohol, tobacco and substance abuse for patients 12 years old and

older. Query history of abuse by the time the patient has been seen three or more times.

- Pertinent history for presenting problem is included.
- There is a pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests are ordered as appropriate by the practitioner
- There are notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. Include the next preventive care visit when appropriate.
- Previous unresolved problems are addressed in subsequent visits.
- Referral pattern appears appropriate. Review for under and over utilization.
- Notes from consultants are in the record.
- All reports show initials of practitioner who ordered them.
- All consult and abnormal lab/imaging results show explicit follow-up plans.
- There is documentation of appropriate health promotion and disease prevention education. Anticipatory guidance is documented at each well child visit.
- An immunization record for children is up to date. Appropriate history has been made in the medical record for adults.
- There is evidence that preventative screenings and services are utilized in accordance with MHW's practice guidelines.

MEDICAL RECORD KEEPING PRACTICES GUIDELINES

Practitioners must demonstrate an overall 80% compliance with the medical record keeping practice guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Review Nurse to ensure correction of the deficiency.

- Each patient has a separate medical record. Records are stored away from patient areas and preferably locked. Record is available at each patient visit. Archived records are available within 24-hours.
- Pages are securely attached in the medical record. Computer users have individual passwords.
- Medical records are organized by dividers or color-coding when the thickness of the record dictates.
- A chronic problem list is included in the record for all adults and children.
- Allergies (and the lack of allergies) are prominently displayed at the front of the record.
- A complete health history questionnaire or H&P is part of the record.
- Health Maintenance forms include dates of preventive services.

- A medication sheet is included for chronic medications.
- Advance Directives discussions are documented for those 18 years and older.
- Record keeping is monitored for Quality Improvement and HIPAA compliance.

Continuity and Coordination of Care

If upon review of medical records, it appears that the referral pattern to specialists may be inappropriate, either for under or over utilization, or there is a pattern of the record not having notes from the consultant, the SRN will immediately notify the MHW Utilization Department Manager for further investigation. Results of the investigation will be sent to the Credentialing Department and the Credentialing Committee will review adverse findings.

Improvement Plans/Corrective Action Plans

Within 30 calendar days of the review, a copy of the medical record review report and a letter will be sent to the PCP medical group notifying them of their results. If the medical group does not achieve the required compliance with the medical record review standards, the SRN will do all of the following:

- Send a letter to the practitioner that identifies the compliance issues
- Send to the practitioner aids such as forms on which to document problems or medication allergies in the medical record
- Conduct another site review of the office in six months

If compliance is not achieved after the second review, the practitioner will be required to submit a corrective action plan (CAP) to MHW within 30 calendar days of notification by MHW. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or practitioner and must include the expected time frame for completion of activities. The SRN conducts additional reviews of the records at six-month intervals until compliance is achieved. The information and any response made by the practitioner, is included in the practitioners permanent credentials file and reported to the Credentialing Committee on the watch status report. If compliance is not attained by the first follow up visit, an updated CAP may be required.

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

As an additional effort to improve medical record keeping practices, MHW also regularly publishes articles in the Provider Newsletter on best practices for medical record documentation.

MEMBER INFORMATION AND MARKETING

Any written informational and marketing materials directed at Molina Healthcare Members must be developed at the sixth grade reading level and have prior written consent from Molina

Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials. Neither Molina Healthcare, nor any contracted Providers or medical groups/IPA may:

- Distribute to its Members informational or marketing materials that contain false or misleading information
- Distribute to its Members marketing materials selectively within the Service Area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for Member enrollment