Molina Medicaid Program

Provider Manual

Molina Healthcare of Illinois

2020

Contents

1.   Introduction

Medicaid Plan
In Illinois, Molina offers two Medicaid health programs as well as a Medicare-Medicaid Plan.

HealthChoice Illinois
The Molina HealthChoice Illinois health plan offers free medical coverage to seniors and people with disabilities, children, pregnant women, families and adults who qualify for Illinois Medicaid. The program was previously known as Family Health Plan and Integrated Care Program.

Health Choice Illinois MLTSS
The HealthChoice Illinois Managed Long Term Support and Services (MLTSS) plan provides waiver and other services to individuals who qualify for both Medicare and Medicaid, but who are not part of the Medicare-Medicaid Alignment Initiative.

2.   Contact Information for Providers

Molina Healthcare of Illinois
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

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.

Web Portal	Phone
https://provider.MolinaHealthcare.com	(855) 866-5462

Member Services Department
The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCP), and Member complaints. Member Services Representatives are available seven (7) days a week, from 8:00 a.m. to 8:00 p.m., local time, excluding holidays. Eligibility verifications can be conducted at your convenience via Molina's web portal.

Phone	Hearing Impaired (TTY/TDD)
(877) 901-8181 (English & Spanish)	711

Claims Department
Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal).
- Access the Provider Portal
- EDI Payer ID number 20934

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions contact Provider Services.

Web Portal	Phone
https://provider.MolinaHealthcare.com	(855) 866-5462

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

Address	Fax
Molina Options Plus Claims Recovery Department PO Box 2470 Spokane, WA 99210-2470	(855) 260-8740

Compliance/Anti-Fraud Hotline

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	Website	Address
(866) 606-3889	https://MolinaHealthcare.alertline.com	Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802

24-Hour 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 twenty-four (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year		
English Phone	**Spanish Phone**	**TTY/TDD**
(888) 275-8750	(866) 648-3537	711 Relay

Healthcare Services Department

The Healthcare Services (formerly UM) 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 Authorization/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 to twenty-four/seven (24/7) online submission and status checks.
• Ensures HIPAA compliance.
• Ability to receive real-time authorization status.
• Ability to upload medical records.
• Increased efficiencies through reduced telephonic interactions.
• Reduces cost associated with fax and telephonic interactions.

Molina offers the following electronic Prior Authorizations/Service Requests submission options:
• Submit requests directly to Molina Healthcare of Illinois via the Provider Portal. See Molina's Provider Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.

- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Web Portal	Phone
https://provider.MolinaHealthcare.com	(866) 409-2935

Health Management Level 1 and Health Management Department
Molina's Health Management Level 1 (previously Health Education) and Health Management (previously Disease Management) programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone	TTY/TDD
Member Services (877) 901-8181	711

Behavioral Health
Molina manages all components of covered services for Behavioral Health. For Member Behavioral Health needs, please contact Molina directly.

Phone	TTY/TDD
Member Services (877) 901-8181	711

Pharmacy Department
For pharmacy services, contact:

Phone	TTY/TDD
(855) 866-5462	711

Quality Improvement
Molina maintains a Quality Improvement (QI) Department to work with Members and Providers in administering the Molina Quality Improvement Program.

Phone	Fax
(855) 866-5462	(855) 556-2074

Supplemental Services
Molina offers the following supplemental services benefits.

Service	Vendor Name & Address	Telephone
Dental	Avesis	(800) 327-4462
Vision	MARCH Vision	(888) 493-4070
Transportation	Secure Transportation (Molina's non-emergency transportation vendor)	(844) 644-6353

3.   Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina Healthcare of Illinois Members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization please contact Molina at (855) 866-5462, available 8 a.m. to 5 p.m., CST/CDT Monday to Friday, excluding state holidays.

HealthChoice Illinois Benefits and Covered Services

Service Covered by Molina
Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina at (855) 866-5462 available 8 a.m. to 5 p.m., CST/CDT Monday to Friday, excluding state holidays.

Link(s) to Summary of Benefits
The following web link provides access to the Summary of Benefits guides for HealthChoice Illinois offered by Molina in Illinois, https://www.molinahealthcare.com/members/il/en-US/PDF/Medicaid/member-handbook-healthchoice-illinois.pdf

Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process
The Provider may request a prior authorization for clinically appropriate drugs that are not covered under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.
- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within twenty-four (24) hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within twenty-four (24) hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by MS DOM.
- Molina will allow a seventy-two (72)-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Specialty Drug Services
Many self-administered and office-administered injectable products require prior authorization. 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 Prior Authorization Request Form, is available in the Healthcare Services section of this

Manual. Physician administered drugs require the appropriate 11-digit NDC with the exception of vaccinations or other drugs as specified by CMS.

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

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 Medical Management Program section of this Provider Manual.

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

Access to Behavioral Health Services
Members in need of Behavioral Services can be referred by their PCP for services or Members can self-refer by calling the number on their Molina Healthcare ID card. Also, 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 Summary of Benefits linked above, or by contacting Molina.

Emergency Mental Health or Substance Abuse Services
Members are directed to call "911" or go to the nearest emergency room if they need Emergency Services mental health or substance abuse. Examples of emergency mental health or substance abuse problems are:
- Danger to self or others
- Not being able to carry out daily activities
- Things that will likely cause death or serious bodily harm

Out of Area Emergencies
Members having a behavioral health emergency who cannot get to a Molina approved Providers are directed to do the following:
- Go to the nearest 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 Services, plans will be made to transfer Members to an in-network facility when Member is stable.

Emergency Transportation
When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while in 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 HealthChoice Illinois Members who have non-emergency medical transportation as a Covered Service, Molina covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). This requires a written prescription from the Member's doctor. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina for ground and air ambulance services before the services are given. Prior Authorization not required for vans, taxi, etc. Additional information regarding the availability of this benefit is available by contacting Provider Services at (855) 866-5462.

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/il/medicaid/resource/Pages/prevent.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 at (855) 866-5462.

Immunizations

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

Immunization schedule recommendations from the American Academy of Pediatrics and/or the CDC are available at the following website, https://www.cdc.gov/vaccines/schedules/hcp/index.html.

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

Well Child Visits and EPSDT Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until twenty-one (21) years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and periodicity schedule generally follow the recommendations from the AAP and Bright Futures. Molina providers are eligible for additional reimbursement for the services listed below when billed with appropriate CPT codes as listed in the HFS Healthy Kids Handbook, which can be found online at https://www.illinois.gov/hfs/SiteCollectionDocuments/hk200.pdf.

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current American Academy of Pediatrics, Centers for Disease Control and Prevention Advisory Committee on Immunization Practices Childhood Immunization Schedule, as appropriate
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services

When a screening examination indicates the need for further evaluation, providers must provide diagnostic services or refer members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

We need your help conducting these regular exams in order to meet Molina's targeted State standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well child care, please call our Health Education line at (855) 866-5462.

Prenatal Care

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

Emergency Services

Emergency Services means inpatient and outpatient healthcare services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish Emergency Services. Emergent and urgent care Services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

Nurse Advice Line

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

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

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

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

Children's Behavioral Health Services
Molina's provider network includes the necessary levels of care, with sufficient intensity, required to meet the needs of members. These levels of care include alternatives to institutions, such as Psychiatric Residential Treatment Facilities (PRTFs) and hospitals, when clinically appropriate.

Mobile Crisis Response Services
Molina coordinates with pediatric mental health crisis intervention services available through the Illinois Mobile Crisis Response (MCR) program when a member in crisis can be stabilized in the community. MCR intervention services are a covered benefit for members who are younger than 21 years old.

Molina's mobile crisis response services are modeled after the state program, formerly known as the Screening, Assessment and Support Systems (SASS) program. Molina's model of care for mobile crisis response includes referrals from the CARES Line (800-345-9049) and use of the Illinois Medicaid-Crisis Assessment Tool (IM-CAT) tool. When appropriate, the CARES line will dispatch Molina's contracted crisis responder to the member's location. The first responder then completes the IM-CAT to determine whether the member can be stabilized in the community. Behavioral health providers in the Molina network are required to send results of the IM-CAT and assessment tool to Molina within 24 hours of the completion of MCR screening for a Molina member.

IM-CAT results can be submitted to Molina via secure email or fax.

Email: MHILbehavioralhealthreferrals@MolinaHealthcare.com
Fax: (866) 916-3249

CARES Case Managers
Members who are the subject of a CARES line call are assigned to a Molina case manager to help support their aftercare. These case managers can be a resource for the mobile crisis response team. Molina's partnership with the MCR program will help Molina monitor prioritization of aftercare counseling and psychiatry for its members.

Crisis Intervention Outside of the Mobile Crisis Response Service
If a member seeks crisis intervention service outside of the Molina's MCR Service System and a crisis call is routed to CARES for a crisis referral, Molina will reimburse

CARES at the annual CARES per call rate. Molina will accept invoices from CARES on a monthly basis and return payment to CARES within forty-five (45) days after receiving an invoice for crisis referral services.

Crisis Safety Plan

MCR providers are responsible for creating a crisis safety plan in collaboration with the member and the member's family. The plan should be shared with all necessary medical professionals, including care coordinators, consistent with the authorizations established by consent or release.

Members will be provided with copies of the crisis safety plans:
- Prior to the completion of the crisis screening for any member stabilized in the community; and
- Prior to the member's discharge from an inpatient psychiatric hospital setting.

Providers are responsible for:
- Educating the member's family about the crisis safety plan
- Ensuring that the plan is reviewed with the family regularly
- Updating the plan, as necessary

Inpatient Treatment

MCR providers are responsible for facilitating the member's admission to an appropriate inpatient institutional treatment setting if the member cannot be stabilized in the community. If inpatient treatment is required, the MCR provider will be responsible for informing the member's parents, guardian, caregivers or residential staff about all of the available network providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.

Molina will arrange for the necessary transportation when a member requires transportation assistance to be admitted to an appropriate inpatient institutional treatment setting.

Inpatient psychiatric network providers will administer a physical examination to the member within twenty-four (24) hours after admission to an inpatient institutional treatment setting.

Molina will provide documented procedures to its network providers regarding discharge and transitional planning consistent with the following:
- Planning will begin upon admission;
- Community-based providers responsible for providing service upon the member's discharge will participate in all inpatient staffing by phone, videoconference or in person;
- The care coordinator will notify the member's family and caregiver of key dates and events related to the member's admission, staffing, discharge and transition, and he or she will make every effort to involve the member and the member's family and caregiver in decisions related to these processes;

- The member's care coordinator will speak directly with the member at least once each week;
- The member's care coordinator or network provider will educate and train the member's family on how to use the crisis safety plan while the member is receiving inpatient institutional treatment; and
- The member's care coordinator will participate in and oversee staffing, discharge, and transition processes.

Provider Contracts/Agreements

Molina authorizes its network providers responsible for providing MCR services for CARES to authorize and dispatch MCR services, which will be reimbursed by Molina.
- If CARES is unable to dispatch Molina's MCR service, CARES will engage the fee-for-service SASS program to ensure crisis response to the member.
- If a member is screened, due to necessity, by a non-network provider of SASS services, Molina will pay for the screening at the Medicaid rate.

Molina requires its network providers to notify Molina or the MCR team, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, including psychiatric hospital stays.

Health Management Programs

Health Management

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

Health Education/Disease Management

Molina offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs.

Our programs include:
- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder
- Maternity Screening and High Risk Obstetrics

For more information about our programs, please call: Provider Services Department at (855) 866-5462 (TTY/TDD at 711 Relay). Visit www.MolinaHealthcare.com.

Member Newsletters
Member Newsletters are posted on the www.MolinaHealthcare.com website at least two (2) times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials
Members are able to access our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members can ask their doctor or visit our website.

Program Eligibility Criteria and Referral Source
Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Identified Members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:
- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- Provider referral;
- Nurse Advice Line referral;
- Medical Case Management or Utilization Management; and,
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication.

Provider Participation
Contracted Providers are notified as appropriate, when their patients are enrolled in a health management program. Provider resources and services may include:
- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;

- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and,
- Preventive Health Guidelines.

Additional information on health management programs is available from Molina HCS toll free at (855) 866-5462.

4. Telehealth and Telemedicine Services

Providers are required to comply with all operating policies and procedures adopted by Molina both for providing telehealth services, as described below, as well as taking into account all other areas of this manual that have implications for telehealth.

Telehealth and telemedicine services mean:
- Interaction for clinical purposes by a provider through technology that permits communication between a Member at an originating site and a Participating Provider at a distant site.
- "Originating site" may include home or other location away from provider's clinical setting, as allowed by local regulations.
- This communication is for the purposes of diagnosis, consultation, or treatment, consistent with the provider's scope of practice.
- The communication does not involve in-person contact between the Member and a Participating Provider.
  – During the virtual visit the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the Participating Provider.
  – Services include live interaction through audio and/or video conferencing.

Note: "Provider" does not have to be a medical doctor. A variety of health professionals can be involved in telehealth services, as appropriate under industry and state regulations.

Definitions
Asynchronous Store and Forward Technology means the transmission of a patient's medical information from an originating site to the provider at the distant site. The provider at the distant site can review the medical case without the patient being present. An asynchronous telecommunication system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs visualized by a telecommunication system must be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis and/or treatment plan. Dermatological photographs (for example, a photograph of a skin lesion) may be considered to meet the requirement of a single media format under this provision.

Telehealth means services provided via a telecommunication system.

Telemedicine means the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one location and the rendering provider is at another location.

Telepsychiatry means the use of a telecommunication system to provide psychiatric or behavioral health services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location. A physician, licensed health care professional or other licensed clinician, mental health

professional, or qualified mental health professional must be available at all times at the originating site.

Following are terms used for locations used for real-time service via telecommunications.

- **Originating Site**: Means the location at which the participant receiving the service is located.
- **Distant Site**: Means the location at which the provider rendering the service is located.

Requirements for Telehealth Services

- Telemedicine
  - A physician or other licensed health care professional must be present with the patient at the originating site when medically necessary as determined by the physician or practitioner at the distant site.
  - The distant site provider must be a physician, physician assistant, podiatrist or advanced practice nurse who is licensed by the State of Illinois or by the state where the patient is located.
  - The originating and distant site provider must not be terminated, suspended or barred from the state and federal medical programs.
  - Medical data may be exchanged through a telecommunication system.
  - The interactive telecommunication system must, at a minimum, have the capability of allowing the consulting distant site provider to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds, as well as clear video images of the patient and any diagnostic tools, such as radiographs, as appropriate for the condition being evaluated.

- Telepsychiatry

Figure 4.2: Quality Withhold Measures for Demonstration Years 2-8

Measure	Source	CMS Core Withhold Measure	Illinois Withhold Measure
Encounter Data	CMS-defined measure	X	
Plan All-Cause Readmissions	NCQA/HEDIS	X	
Annual Flu Vaccine	AHRQ/CAHPS	X	
Follow-up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	CMS/PDE Data	X	
Care for Older Adults (COA) **For Demonstration Years 2-5 only**	NCQA/HEDIS		X
Adults' Access to Preventive/Ambulatory Health Services (AAP) **For Demonstration Years 6-8 only**	NCQA/HEDIS		X
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA/HEDIS		X
Movement of Members Within Service Populations	State-defined measure		X

- A physician, licensed health care professional or other licensed clinician, mental health professional (MHP), or qualified mental health professional (QMHP), as defined in 59 Ill. Adm. Code 132.25, with the patient at the originating site when medically necessary as determined by the physician or practitioner at the distant site. The distant site provider must be a physician licensed by the State of Illinois and must have completed an accredited general psychiatry residency program or an accredited child and adolescent psychiatry residency program.
- The originating and distant site provider must not be terminated, suspended or barred from the state and federal medical programs.
- The distant site provider must personally render the telepsychiatry service.
- Telepsychiatry services must be rendered using an interactive telecommunication system.
- Group psychotherapy is not a covered telepsychiatry service.

Benefits
Benefits are provided for telemedicine services in all Molina Healthcare jurisdictions when provided in accordance with local state requirements and definitions as described above.

Benefits are not provided for any technical equipment or costs for the provision of telemedicine services. The following additional provisions that apply to the use of telehealth and telemedicine services:
- 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, i.e., room or building.
- Services do not include texting, facsimile or email only.

Member Eligibility and Consent for Telehealth Services
Molina does not discriminate regarding which of our Members may access telehealth services. There are not criteria for their geography or physical proximity to providers. We acknowledge that depending on a Member's situation, they may find additional convenience through telemedicine even if they live in area with many providers located a short distance from them.

Organizations and health professionals providing telehealth services should ensure compliance with relevant legislation, regulations, and accreditation requirements for supporting patient/client decision-making and consent.

Provider organizations should integrate telehealth into existing operational procedures for obtaining consent for treatment from patients. They should provide a mechanism for additional informed consent when required for invasive procedures.

From "ATA Practice Guidelines for Live, On Demand Primary and Urgent Care":
One or more of the following situations means the member is not suitable for care via telehealth:
- Patient has cognitive disorders
- Intoxication

- Cognitive impairment such as autism
- Language barriers, e.g., limited ability to speak and understand English, if an interpreter is not available
- Emergency situation warrants escalation to ER visit or 911
- Patient does not have requisite technology to complete virtual visit

Member can be alone during the visit, as long as this complies with state regulations and they are prepared appropriately for telemedicine encounter.

Special Populations:
1. English as a second language – Provide and document use of interpreter.
2. Comply with American Disabilities Act of 1990 (ADA) and other legal and ethical requirements.
3. Pediatric – Encounters require the presence and/or active participation of a caregiver or facilitator, including parent/guardian, nurse, and/or childcare worker. The practitioner should obtain consent from the parent or legal representative of the child as required by law in the respective jurisdiction. With parental consent, it is acceptable for a minor to have a telehealth session alone without a caregiver or facilitator present in the same room.
   a. Age of Consent: Minors in all states have the right to consent to testing and treatment for a sexually transmitted disease (STD).
   b. Abuse: In the evaluation of child abuse and/or sexual abuse, state child protective rules supersede individual Privacy and FERPA regulations for consent.
      i. Images captured for the evaluation of child abuse and/or sexual abuse should follow Store and Forward guidance for safety, security, privacy, storage, and transmissions as well as institutional policies.
   c. Homebound / Geriatric – Providers should have the patient affirm consent to family members/caregivers, and nurses that would facilitate the visit and decision-making. If the patient is in a care facility or senior living community, a trained technician may assist in collecting relevant clinical information, including medical records, lab or diagnostic testing, and access to caregivers and staff. Providers should take into account the special needs of the elderly, and take these into account when designing and choosing technology configuration for telehealth equipment and systems.

The member or their guardian need to have the option to consent to use of telehealth for services, instead of care delivered in person, when telehealth is reasonable for the condition being treated. This consent should be documented and include:
1. Description so patient understands how telehealth service compares to in-person care. Apprise patients of their rights when receiving telemedicine, including the right to suspend or refuse treatment.
2. Apprise patients of their own responsibilities when participating in telehealth.
3. Inform patients of a formal complaint or grievance process to resolve ethical concerns or issues that might arise as a result of participating in telehealth.
4. Record keeping – Process by which patient information will be documented and stored.

5. Privacy and security – limits to confidentiality in electronic communication. Discuss the potential benefits, constraints and risks (e.g., privacy and security) of telehealth.
6. Potential Risks – include an explicit emergency plan (particularly for patients in settings without access to clinical staff). The plan should include calling the patient via telephone and attempting to troubleshoot the issue together. It may also include referring the patient to another provider, or completing the encounter by voice only.
7. Credentials of the distant site provider and billing arrangements – Information provided should be in simple language that can easily be understood by the patient. This is particularly important when discussing technical issues like encryption or the potential for technical failure.
8. Potential for technical failure – Contingency plan that is communicated to the patient in advance of the telehealth encounter.
9. Procedures for coordination of care with other professionals.
10. A protocol for contact between visits.
11. Prescribing policies including local and federal regulations and limitations
12. Conditions under which telehealth services may be terminated and a referral made to in-person care.
13. Description of appropriate physical environment free from distractions, conducive for privacy and proper lighting/background noise.
14. Inform patients and obtain their consent when students or trainees observe the encounter.
15. Patients should consent in writing prior to any recording of the encounter.

Privacy and Security
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 Protected Health Information (PHI).

Refer to the Compliance section of this manual for information about the HIPAA (The Health Insurance Portability and Accountability Act).

Geography and Physical Environment for Telehealth Services
- Originating Site Environment for Member
  - Written instructions to prepare the member to participate in telehealth should explain standards for PHI using telehealth. When the originating site will be located in the community away from the provider's usual clinical setting, prior to the session the care team should encourage the patient to select an appropriate location that will support a private conversation about their health.
- Distant Site Environment for Provider
  - Just as for in person visit, during a telehealth interaction the provider needs to be situated in a location that is conducive to secure private communication with the patient.
  - The provider should minimize distraction, background noise and other environmental conditions that may affect the quality of the encounter. For clear visibility online, it is helpful to have light facing the provider and reduce background lighting behind them.

- The environment should meet standards for privacy and confidentiality.
- Personal health information not specific to the patient being examined should not be visible.

Contingency Support for Member
The provider should have an emergency or contingency plan that is communicated to the patient/staff at originating site in advance of the telemedicine encounter. This includes alternate options to continue communication, if the session dialogue is disrupted or severed due to technical issues.

Fraud and Abuse Protocols
Provider is required to have protocols to prevent fraud and abuse related to delivery of services via telemedicine. These protocols must address:
- Authentication and authorization of users;
- Authentication of the origin of the information;
- The prevention of unauthorized access to the system or information;
- System security, including the integrity of information that is collected, program integrity and system integrity; and
- Maintenance of documentation about system and information usage.

Provider Directory Listing
Molina offers a visual icon in our Provider Online Directory (POD) that indicates whether a provider offers any telehealth services. Please notify your provider network manager as soon as possible if your organization adds telehealth capabilities, so we can update this data field and identify this option appropriately.

Claims and Billing
Providers must follow CMS guidelines as well as state level requirements.

For additional information refer to the CMS MLN Matters Number: 901705 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327.html.

All telehealth claims for Medicaid members must be submitted to Molina with correct codes for the plan type. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.

The distant site is the site where the provider rendering the telehealth service is located. Maximum reimbursement to distant site providers should be the department's rate for the CPT code for the service rendered. The appropriate CPT code must be billed with modifier GT (via interactive audio/video telecommunication systems) and the appropriate Place of Service Code, 02, telehealth.

Subcontract Relationships for Telehealth Services
Providers should make known to Molina the name(s) of any outside company(ies) that it uses for the provision of telehealth services, whether they are technology or clinical subcontractors.

If the role of the subcontractor organizations could include billing the member directly, then they need to be credentialed/established as a participating provider.

Providers should ensure and certify that a Business Associates Agreement (BAA) is in place with outside organizations with whom they contract for telehealth support. This BAA should be shared with Molina if requested.

Provider should consider the option to have their telehealth services /vendors accredited and should notify Molina if this accreditation is achieved by external organizations, e.g., American Telemedicine Association, The Joint Commission and URAC.

Provider should notify Molina promptly upon becoming aware of a change in its technology platforms or vendor's accreditation. In the event of such a change, Molina and provider should discuss any such changes in good faith.

Administrative Standards

For Organizations
Organizations providing services via telehealth should follow the standard operating policies and procedures as set by the State of Illinois. These also apply to collaborative partnerships, where there are telehealth services offered,

- If the telehealth operation is a sole entity or part of a solo practice, that entity or solo practice should have policies and procedures in place that responsibly include and address aspects of telehealth as part of governance of all administrative functions with regard to:
  - Human resource management;
  - Privacy and confidentiality;
  - Federal, state, and other credentialing and regulatory agency requirements;
  - Fiscal management;
  - Ownership of patient records;
  - Documentation;
  - Patient rights and responsibilities;
  - Network security;
  - Telehealth equipment use; and
  - Research protocols
- Organizations providing telehealth programs should have in place a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management.
- Organizations should have a mechanism in place for assuring that patients are aware of their rights and responsibilities with respect to accessing health care via telehealth technologies, including the process for communicating complaints.

For Health Professionals
Provider Credentialing and Licensure for Telehealth
Providers should follow federal, state, and local regulatory and licensure requirements related to their scope of practice, and will abide by state board and specialty training requirements.

Molina does not maintain specific credentialing beyond state standards for providers who deliver services via telehealth.

The member's geographic location at Originating Site affects the requirements for the provider. Telemedicine services must be in compliance with the state level requirements for the member's location during these services. Provider should ensure that the patient is physically located in a jurisdiction in which the provider is duly licensed and credentialed. Typically, telehealth services must be provided by providers who are licensed to practice medicine within the state where the member physically is located at time of service.

The following guidelines apply in order to be eligible to receive reimbursement for telehealth services.
- All providers must be successfully complete standard credentialing by Molina.
- If the state also requires any type of license for delivery of telemedicine services, this must be documented for Molina as part of the credentialing process.
- Geography: Telehealth services must be provided by providers who are licensed to practice medicine within the state where the member physically is located at time of service.

Scope of practice:
- Health Professionals should be aware of their locus of accountability and any/all requirements (including those for liability insurance) that apply when practicing telehealth in another jurisdiction.
- Health Professionals using telehealth should be cognizant of when a provider-patient relationship has been established within the context of a telemedicine Encounter between the health care provider and the patient, whether interactive or store-and-forward, and proceed accordingly with an evidence-based, best possible standard of care.
- Health Professionals providing telehealth covered services should have the necessary education, training/orientation, and ongoing continuing education/professional development recommended for their scope of practice to ensure they possess the necessary competencies for the safe provision of quality health services in their specialty area.
- Health professionals should have the requisite training, and ensure ongoing compliance with HIPAA and the HITECH Act in their provision of a telemedicine Encounter.

Clinical Standards
- Telemedicine providers should determine the appropriateness of telemedicine on a case-by-case basis. Especially when the originating site is a professionally

unsupervised setting (e.g. patient's home), the provider should evaluate whether the patient can remain safe and handle the more active role required for the treatment process away from in –person settings.

- For treatment occurring over several or more sessions over time: the provider should evaluate ongoing the appropriateness of using telehealth format for care delivery. If there is any concern that the patient could be better served through services in person, then the provider should communicate this change to the patient and support transitioning their sessions to face-to-face care if possible or to or with another provider as necessary.
- Provider should respect patient's wishes for format of care i.e. patient has the right to decline starting care via telehealth, and also may request to switch from telehealth to care delivered in person with the same provider or another practitioner as appropriate.
- The organization and health professionals should be satisfied that Health Professionals providing care via telehealth are aware of their own professional discipline standards and those standards should be upheld in the telehealth encounter, considering the specific context, location, and timing, and services delivered to the patient.
- Health professionals should be guided by professional discipline and national existing clinical practice guidelines when practicing via telehealth. It will be beneficial to review specialty society guidelines and evidence published in peer-reviewed literature. Any modifications to specialty-specific clinical practice standards for the telehealth setting should ensure that clinical requirements specific to the discipline are maintained.
- Provider-directed patient self-examination to include the use of peripheral devices as appropriate. This examination may include a demonstration, or an explicit physician-guided self-examination required to confirm the diagnosis, the provider should recommend to the patient that such testing be performed in accordance with standards of medical care.
- Covered services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.

Clinical documentation for legal and regulatory considerations:
- Providers should be aware if the patient is physically located in a jurisdiction in which the provider is duly licensed and credentialed.
- Providers should document the patient's physical location at the time of the telehealth encounter.
- If the patient is not located at a known originating site, then the provider should document the patient's stated location in the medical record.

Special considerations may vary by state for pediatrics which include, but are not limited to: consent, parental presence, requirements for establishing a physician-patient relationship, prescribing, prescribing controlled substances, handling of images, and age of majority.

Provider should provide the originating site with their contact information, including telephone, practice address, and email. It is not necessary for the provider to reveal their specific location to the patient, especially if the provider is located at home at the time of service.

Emergent Encounters via Telehealth
Providers will document:
1. The process of treating emergent situations, which may include phoning the receiving facility in advance of the patient's arrival.
2. Document all referrals to EMS (dialing 911) including the medical indication/basis for the recommendation, and nature of the problem.
3. Document the location of the patient at the start of the encounter.
4. Document any extenuating circumstances or adverse events, be they technical or clinical, which occurred during the encounter.
5. Documentation should adhere to all medical-legal standards of care, and if appropriate, insurance requirements for future review and audit.

Technical Standards
- Organizations should ensure that equipment sufficient to support diagnostic needs is available and functioning properly at the time of clinical encounters.
- Organizations should maintain current versions of hardware and software systems and applications.
- Organizations should have strategies in place to address the environmental elements of care necessary for the safe use of telehealth equipment.
- Organizations should comply with all relevant safety laws, regulations, and codes for technology and technical safety, as well as those required by HIPAA's Security Rule and HITECH Act.
- Organizations should have infection control policies and procedures in place for the use of telehealth equipment and patient peripherals that comply with organizational, legal, and regulatory requirements.
- Organizations providing telehealth services should have policies and procedures in place to comply with local legislated and regulatory rules for protection of Patient Protected Health Information and to ensure the physical security of telehealth equipment and the electronic security of data.
- Organizations should have appropriate redundant systems and communications plans in place that ensure availability of the network for critical connectivity. This includes clinical video and exam equipment for critical clinical encounters and functions.
- Organizations should have plans in place to provide support for the patient and provider in case of technical malfunction during a telehealth session.
- Organizations should meet required published technical standards for safety and efficacy for devices that interact with Members or are integral to the diagnostic capabilities of the practitioner when and where applicable.
- Organizations providing telehealth services should have processes in place to ensure the safety and effectiveness of equipment through on-going maintenance and review of performance.

Upon at least ten (10) days prior notice to provider, Molina should further have the right to a demonstration and testing of provider' telehealth service platform and operations. This demonstration may be conducted either virtually or face to face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider should make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

Glossary

- Asynchronous or "store and forward" – Transfer of information from one site to another through the use of a camera or similar device to record an image or data.
- Distant or hub site – Site at which the provider delivering the service is located.
- Distant site practitioner – Provider at a distant site who furnishes and receives payment for covered telehealth services.
- Originating or Spoke site – Location of the patient at the time the service is provided.
- Remote patient data transfer –Remote data transfer requires no active participation by the patient. The treating provider uploads and sends imaging or pathologic information to a remote consultant for interpretation. This transmission generally is asynchronous.
- Remote patient monitoring – Remote monitoring of patient data does not convey verbalized communication by the patient. Biophysical data (e.g., cardiac telemetry) is transmitted to a physician or medical facility for synchronous or asynchronous interpretation.
- Synchronous – Simultaneous data information transfer in both directions.
- Telehealth –Telemedicine may be considered a part of the global term "telehealth." In common use it refers to a patient encounter with a provider by electronic means either synchronously or asynchronously.
- Video Consultation –The patient is in live synchronous video and audio communication with the provider.

Resources for Telehealth Policies, Best Practices and Regulations

- American Telemedicine Association – guidelines, regulations, accreditation, http://www.americantelemed.org
- The Joint Commission – accreditation, https://www.jointcommission.org/
- URAC – accreditation, https://www.urac.org/programs/telehealth-accreditation
- Center for Connected Health Policy, http://www.cchpca.org/
- Regional Telehealth Resource Centers, https://www.telehealthresourcecenter.org/

5.   Long Term Services and Support (LTSS)

LTSS Overview
LTSS includes both Long-Term Care (LTC) and Home and Community Based Services (HCBS).
- Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility).
- Home and community-based services programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community. The programs serve people who are older adults, or people with disabilities.

Molina understands the importance of working with our Providers and Community Based Organizations (CBO's) in your area to ensure our Members receive LTSS services that maintain their independence and ability to remain in the community.

Molina's LTSS Provider Network is a critical component to ensuring our Members receive the right care, in the right place, at the right time. The following information has been included to help support our LTSS Provider network and achieve a successful partnership in serving those in need.

LTSS Services and Molina Healthcare
Molina offers services to Members of the following waiver programs:
- Persons who are Elderly
- Persons with Disabilities
- Persons with HIV/AIDS
- Persons with Brain Injury
- Supportive Living Facility

Services offered under these waivers are designed to assist Members maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in their home or a cost-effective home-like setting. Services for eligible Members are provided in the Member's home or assisted living facility. These waiver programs provide eligible individuals the ability to choose and receive the care they need in the home or community rather than in an institution.

LTSS Benefits and Approved Services
Adult Day Service - Provides direct care and supervision of adults aged 60 and older in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting.

Adult Day Health Transportation - Provides transportation from a Member's home to the Adult Day Health facility. Does not include transportation to any other service.

Day Habilitation - Day habilitation assists with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a non-residential setting, separate from the home or facility which the Member resides. The

focus is to enable the Member to attain or maintain his or her maximum functional level. Day habilitation shall be coordinated with any physical, occupational, or speech therapies. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Environmental Accessibility Adaptations - Provides physical adaptations to the home required by the Member's Care Plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the Member to function with greater independence in the home, and without which, the Member would require institutionalization.

Home Delivered Meals - Prepared food brought to the Member's residence that may consist of a heated luncheon meal and/or a dinner meal which can be refrigerated and eaten late.

Homemaker - This service pays two (2) different prices – one for agencies that do not pay for employee insurance and one for agencies that do. The provider information regarding which agency will pay employee insurance and which agency will not pay employee insurance will be on the waiver-approved provider list that Molina Healthcare will receive from the state. Homemaker service is defined as general non-medical support by supervised and trained homemakers. Homemakers are trained to assist Members with their activities of daily living, including Personal Care, as well as other tasks such as laundry, shopping, and cleaning.

Personal Emergency Response System (PERS) - PERS is an electronic device that enables certain Members at high risk of Institutionalization to secure help in an emergency. The Member may also wear a portable "help" button to allow for mobility. The system is connected to the Member's phone and programmed to signal a response center once a "help" button is activated. PERS services are limited to those Members who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Respite - Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the Member. Services are limited to Individual Provider, homemaker, nurse, adult day care, and provided to a Member to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.

Skilled Nursing Services RN/LPN - Service provided by an individual that meets Illinois licensure standards for nursing services and provides shift nursing services.

Specialized Medical Equipment and Supplies - Specialized medical equipment and supplies includes devices, items, and appliances that enables the Member to perform activities of daily living (ADL). Limit – Items over $500.00 will require three competitive bids.

Supported Employment - Provides supported employment services that consist of intensive, ongoing supports that enable Members, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. It may include assisting the Member to locate a job or develop a job on behalf of the Member, and is conducted in a variety of settings; including work sites where persons without disabilities are employed.

Personal Care Services (Individual Provider) - This is a self-directed service. This service is reimbursed by IHFS. Individual Providers provide assistance with eating, bathing, personal hygiene, and other activities of daily living. This service may also include such housekeeping chores as bed making, dusting, vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the Member's family. Personal Care Services are a covered benefit for the following waivers: People with Disabilities, HIV/AIDS and Traumatic Brain Injury.

Home Health Aide - Provides services by an individual that meets IL licensure standards for a Certified Nursing Assistant. Services provided are in addition to any services provided through the State Plan.

Nursing, Intermittent - Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the State. Nursing through the HCBS Waiver focuses on long term habilitative needs rather than short-term acute restorative needs. HCBS Waiver intermittent nursing services are in addition to any Medicaid State Plan nursing services for which the Member may qualify.

Therapies - Service provided by a licensed therapist that meets Illinois standards. Services are in addition to any Medicaid State Plan services for which the Member may qualify. Therapies through the Waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Prevocational Services - Prevocational services are aimed at preparing a Member for paid or unpaid employment, but are not job-task oriented. This can include teaching concepts such as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to Members expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Assisted Living (Supportive Living) - The Supportive Living Program serves as an alternative to Nursing Facility (NF) placement, providing an option for seniors 65 years of age or older and persons with physical disabilities between 22 and 64 years of age who require assistance with activities of daily living, but not the full medical model available through a nursing facility. Members reside in their own private apartment with kitchen or kitchenette, private bath, individual heating and cooling system and lockable entrance.

Behavioral Health Services (M.A and PH.D) - Remedial therapies to decrease maladaptive behaviors and/or to enhance the cognitive functioning of the Member to increase their capacity for independent living.

LTSS Services by Waiver Program

Benefit	Persons who are Elderly	Persons with Disabilities	Persons with HIV/AIDS	Persons with Brain Injury	Supportive Living Facility
Adult Day Health (ADH)	X	X	X	X	
Adult Day Health (ADH) Transportation	X	X	X	X	
Assisted Living (Supportive Living)					X
Automatic Medication Dispenser (AMD)	X				
Behavioral Health Services (M.A and PH.D)				X	
Day Habilitation				X	
Environmental Accessibility Adaptations		X	X	X	
Home Delivered Meals		X	X	X	
Home Health Aide		X	X	X	
Homemaker Services	X	X	X	X	
Nursing, Intermittent		X	X	X	
Personal Care Services (Individual Provider)		X	X	X	
Prevocational Services				X	
Respite		X	X	X	
Skilled Nursing Services LPN		X	X	X	
Skilled Nursing Services RN		X	X	X	
Specialized Medical Equipment and Supplies		X	X	X	
Supported Employment				X	
Therapies		X	X	X	

Getting Care, Getting Started

Molina care coordinator will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and LTSS services. Specifically, along with providing the fully integrated Individualized Plan of Care (IPoC), the care coordinator will provide verbal, written and/or alternate format information on:

- After-hours assistance for urgent situations
- Access to timely appointments
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication
- Advocacy, engagement of family members and informal supports

At a minimum, the care coordinator's name, contact information and hours of availability are included in the care plan, which is shared with all Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All care coordinators are required to keep email and voicemail current with availability or backup as necessary for Members and their Providers.

Molina will ensure the provision of the following service coordination services for the Members:

- LTSS Service Coordination
- Care and Service Plan Review
- Crisis Intervention
- Event Based Visits
- Institution-based Visits
- Service Management
- Medicaid Resolution
- Assessment of LTSS Need
- Member Education

Molina will work closely with the various Community Based Organizations (CBO's) for home and community based services (HCBS) to ensure that the Member is getting the care that they need.

Once you have been identified as the Provider of service, it will be your responsibility for billing of these services. The Individualized Care Plan (ICP) will document services, duration, and any other applicable information.

Care Management Team or Integrated Care Team or Interdisciplinary Care Team (ICT)

All MLTSS Members will receive care coordination and be assigned a Care Coordinator from Molina.

The care management team for MLTSS will include at a minimum the Member and/or their authorized representative, Care Coordinator and PCP.

The person centered Integrated Care Team (ICT) will include at minimum the Member and/or their authorized representative, Care Coordinator and anyone a Member

requests to participate. ICT Members may also include LTSS Providers (e.g., Services Facilitator, Adult Day Health Care Center staff, assistive technology, transition coordinator, Nursing Facility staff, etc.), PCP, specialist(s), behavioral health clinician, Targeted Case Management Service Providers, and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.

Individualized Care Plan Coordination
LTSS services to be covered by Molina will require coordination and approval.

The Individualized Care Plan (ICP) includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The ICP includes informal care, such as family and community supports. Molina Healthcare of Illinois will ensure that a person centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A Person Centered Service Plan means the plan that documents the amount, duration, and scope of the home and community based services. The service plan is person centered and must reflect the services and supports that are important for the Member to meet their needs, goals and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301).

The Individualized Care Plan (ICP) will be developed under Member's direction and implemented by assigned Members of the Interdisciplinary Care Team (ICT) no later than the end date of any existing Service Authorization (SA) or within the state specific timeframes for initial and reassessments. All services and changes to services must be documented in the ICP and be under the direction of the Member in conjunction with the care coordinator.

The Integrated Care Team (ICT) under Member's direction, is responsible for developing the ICP, and is driven by and customizable according to the needs and preferences of the Member. As a Provider you may be asked to be a part of the ICT.

Additional services can be requested through the Member's care coordinator anytime including during the assessment process and through the ICT process. Additional services needed must be at the Members direction and can be brought forward by the Member, the care manger, and/or the ICT team as necessary. Once an additional need is established, the care plan will be updated with the Member's consent and additional services approved. For additional information regarding MLTSS service coordination and approvals in the Member's ICP, please contact Molina at (855) 687-7861.

Transition of Care Programs

Molina has goals, processes and systems in place to ensure smooth transitions between Member's setting of care and level of care. This includes transitions to and from inpatient settings (i.e., Nursing Facility to Home).

All care coordinators are trained on the transitions of care approach that Molina follows for transitions between care settings. The care coordinators can use tablet technology to facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

Continuity of Care (COC) Policy and Requirements

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans, level of care, and Providers (including out-of-network Providers) for ninety (90) days.

Ongoing Provider support and technical assistance will be provided especially to community behavioral health, LTSS Providers, and out of network Providers during the continuity of care period. All existing Integrated Care Plans (ICPs) and Service Authorizations (SAs) will be honored during the transition period of ninety (90) days.

A Member's existing Provider may be changed during the ninety (90) day transition period only in the following circumstances: (1) the Member requests a change; (2) the Provider chooses to discontinue providing services to a Member as currently allowed by Medicaid; (3) Molina or Illinois Healthcare and Family Services identify Provider performance issues that affect a Member's health or welfare; or (4) the Provider is excluded under State or Federal exclusion requirements.

Out-of-network Providers who are providing services to Members during the initial continuity of care period shall be contacted to provide them with information on becoming credentialed, in-network Providers. If the Provider chooses not to join the network, or the Member does not select a new in-network Provider by the end of the ninety (90) day transition period, Molina will work with the Member in selecting an in-network Provider.

Members in a Nursing Facility (NF) at the time of Molina MLTSS enrollment may remain in that NF as long as the Member continues to meet nursing facility level of care, unless they or their family or authorized representative prefer to move to a different NF or return to the community. The only reasons for which Molina may require a change in NF is if (1) Molina or Illinois Healthcare and Family Services identify Provider performance issues that affect a Member's health or welfare; or (2) the Provider is excluded under State or Federal exclusion requirements.

Reassessments will be completed as necessary and IPoCs updated, Molina will review IPoCs of high-risk (Level 3) Members at least every thirty (30) days, and of moderate-risk (Level 2) Members at least every ninety (90) days, and conduct reassessments as necessary based upon such reviews. At a minimum a health-risk reassessment will be

conducted annually for each Member who has an IPoC. In addition, a face-to-face health-risk reassessment will be conducted for Members receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Member's condition or a Member requests reassessment. The updated IPoCs will be provided to providers that are involved in providing Covered Services to Members within no more than five (5) Business Days.

For additional information regarding continuity of care and transition of MLTSS Members, please contact Molina at (855) 687-7861.

Members have the choice of how their services are delivered through various models, which may include consumer-direction. The Molina Care Coordinator will work with the Member or their designee to ensure the Member meets the criteria for consumer direction.

Claims for LTSS Services
Providers are required to bill Molina for all services.
- For long term care claims, they must be billed electronically.
- For waiver related claims, we accept those electronically through the EDI platform, through our web portal, and by mail. To register please visit: Provider Self Services Web Portal.

Billing Molina
For detailed billing information see the appendices at the end of this section.

All HCBS waiver services with the exception of personal care workers are billing to Molina on a professional claim form. There is a listing of codes, units, services and taxonomy numbers at the end of the document. In the absence of an NPI, providers should bill with their 12-digit HFS provider ID specifically related to the waiver service. For example, if services are for a member on the Elderly waiver, bill using the HFS provider number registered for provider type 090.

Long term care claims are billed on an 837I and do require several key data elements including but not limited to:
- Original admission date should be on the claim
- Be mindful of bill type, especially for interim bills
- Taxonomy codes are required and provided in the billing guidelines
- All claims are subject to our patient credit file validation process and the application of any member liability
- Value code 80 must be on the claim for all covered days
- Value code 81 must be on the claim for all non-covered days

Atypical Providers
Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include Adult Day Care, Respite Care, and Homemaker Services. Although they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina Healthcare of Illinois.

When billing Molina for LTSS Services, as an atypical provider, refer to the Appendix for more detailed information.

Timely Filing Processing
Most Molina contracts have timely filing language of 180 days.

Claims Submission: Provider Portal
We encourage our MLTSS Providers to utilize the Molina Provider Portal to submit claims. Please see the Claims and Compensation section of this manual or the [Portal Quick Reference Guide](#) for further details. You may also contact your provider network manager or email the Provider Network Management Department at MHILProviderNetworkManagement@MolinaHealthcare.com.

Timely Claims Processing
Typically, claims are processed within 30 days.

Billing Molina Members
Providers may not bill members. Balance billing is not allowed

There is no member liability with the exception of members in a custodial LTC setting. For members who are living in a LTC facility, SMHRF, ICF/MI or a SLF, the member may have a cost share related to their income. The state determines the member's income and patient liability. That information is shared with Molina via the Patient Credit File.

In order for the claim to be considered for payment, the member must be on the patient credit file for the dates of services, and the provider billing must also be on the patient credit file. This includes both the LTC provider and when applicable the hospice provider if the member is in a LTC and receiving hospice services.

Any member income will be subtracted from the room and board charge line and for SLF from the ancillary services (revenue code 0240). For members living in a LTC receiving hospice-related services, the income will be reduced from the room and board charges (revenue code 0658).

Provider Claims Dispute (Adjustment Request)
A request to review the processing, payment or non-payment of a claim by Molina shall be classified as a Provider Claim Dispute and can be submitted through one of the following options:
- Web Portal: Providers are strongly encouraged to use the Molina Web Portal to submit Provider Claims Disputes
- Fax: Provider Claims Disputes can be faxed to Molina at: (855) 502-4962. Must also contain a completed Claims Dispute Form
- Note: CD's containing medical records may be sent to: Molina Healthcare of Illinois, Attention Provider Disputes, 1520 Kensington Rd., Suite 212, Oak Brook IL 60523. Must include completed Claims Dispute Form

Provider Complaints

Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid Waiver (s) for which they are certified/approved. Each entity that pays claims will review Provider's documentation to verify that services authorized and paid for are actually provided. Providers must work with the Molina first before submitting complaints to the state agency.

Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina that does not pertain to a benefit or claim determination. Complaints may be submitted no later than thirty (30) calendar days form the date the provider becomes aware of the issue generating the complaint.

Appendix 1: Home and Community Based Services (HCBS) Codes

Service	Code	Modifier	Taxonomy*	Billing Increment
Adult Day Service	S5100		261QA0600X	15 min
Adult Day Service Transportation	T2003		261QA0600X	1 unit = one way trip
Environmental Home Adaptations -Contractor -Vehicle	S5165		-171W00000X -171WV0202X	Per service. Service maximum is $25,000 combined over a 5-year period.
Automatic Medication Dispenser (AMD)	A9901		332B00000X	1 unit per month
Supported Employment	T2019		251S00000X	15 min
Home Health Aide – Agency	T1004		251E00000X	15 min
Home Health Aide – Agency – CNA	T1004	SC	251E00000X	15 min
Home Health Aide – Individual	G0156		251E00000X	15 min
Home Health Aide – Individual – CNA	G0156	SC	251E00000X	15 min
Home Health – Intermittent Nursing RN, LPN (Agency Provider)	G0154		251E00000X	15 min
Home Health – Intermittent Nursing RN, LPN (Agency Provider)	G0154	SC	251E00000X	15 min
Nursing, Skilled – LPN Agency	T1003	TE	253Z00000X	15 min
Nursing, Skilled – LPN Individual	T1000	TE	253Z00000X	15 min
Nursing, Skilled – Multi-Customer	T1002	TT	253Z00000X	15 min
Nursing, Skilled RN Agency	T1003	TD	253Z00000X	15 min
Nursing, Skilled RN Individual	T1000	TD	253Z00000X	15 min
Occupational Therapy	G0152	UC	225X00000X	15 min
Physical Therapy	G0151	UC	225100000X	15 min
Speech Therapy	G0153	UC	235Z00000X	15 min
Speech Therapy – Hospital	G0153	UC	235Z00000X	15 min
Supportive Living Facilities	Follow long term care billing requirements		310400000X	Per diem
Prevocational Services	T2014		251S00000X	Per diem
Habilitation – Day	T2020		261QR0400X	Per diem
Homemaker	S5130		376J00000X	15 min
Homemaker with Insurance	S5130		376J00000X	15 min
Home Delivered Meals	S5170		332U00000X	Per meal
Personal Assistant	S5125	Billed through Electronic Visit Verification Process		
Personal Emergency Response – Install	S5160		146D00000X	Per install
Personal Emergency Response – Monthly Charge	S5161		146D00000X	Per month
Respite – RN	T1005	TD	385H00000X	15 min
Respite – LPN	T1005	TE	385H00000X	15 min
Respite – CNA	T1005	SC	385H00000X	15 min
Respite – Homemaker	T1005	HM	385H00000X	15 min
Respite – Personal Assistant	T1005		385H00000X	15 min
Specialized Medical Equipment	T2028	RR	332B00000X	Per service

* There may be other taxonomy numbers accepted, however these are the recommended codes for Molina.

Appendix 2: Nursing Facility Billing Guidance

Nursing Facility claims can only be submitted via the 837I (electronic/EDI submission).
The Nursing Facility Billing Guidance for Illinois are listed below.

Provider Type 028 Alzheimer/Dementia Center Taxonomy Code: 311500000X										
Bill Type FL 04	Bill Type Description	Inpatient or Outpatient	Legacy Cos	Legacy Cos Description	Revenue Code FL 42	Revenue Code Description	Occurrence Code FL 31-34	Occurrence Span Code FL 35-36	Value Code FL 39-41	Value Code Description
089X	Special Facility - Other	OP	86	LTC SLF Dementia Care	0240	All Inclusive Ancillary/General		N/A	80	Covered Days
089X	Special Facility - Other	OP	86	LTC SLF Dementia Care	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
Provider Type 028 Assisted Living Facility Taxonomy Code: 310400000X										
089X	Special Facility - Other	OP	87	LTC - Supportive Living Facility (Waivers)	0240	All Inclusive Ancillary/General		N/A	80	Covered Days
089X	Special Facility - Other	OP	87	LTC - Supportive Living Facility (Waivers)	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
Provider Type 033 Skilled Nursing Facility Taxonomy Code: 314000000X										
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	70	LTC - Skilled	0110 - 0160*	General Room & Board Values	*If Recipient Has Medicare Part A* A2 - Eff. Date Of Medicaid A3 - Benefits Exhausted B3 - Benefits Exhausted - Payer B 22 - Date Active Care Ended 25 - Date Benefits Terminated	N/A	80	Covered Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	70	LTC - Skilled	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered

Provider Type 033 Skilled Nursing Facility **Taxonomy Code: 314000000X**										
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	**65	LTC Full Medicare Coverage	0110 - 0160*	General Room & Board Values		70	80	Covered Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	**72	LTC-NF Skilled- Co-Ins(partial Medicare coverage)	0110 - 0160*	General Room & Board Values		70	82	Co Ins. Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	38	Exceptional Care - TBI Level I Exceptional Care - TBI Level II Exceptional Care - TBI Level III Exceptional Care - VENT	0191 0192 0193 0194	Subacute Care - Level I Subacute Care - Level II Subacute Care - Level III Subacute Care - Level IV		N/A	80	Covered Days
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/Training				
Provider Type 033 Nursing Facility / Intermediate Care Facility **Taxonomy Code: 314000000x**										
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/ Training		N/A		
Provider Type 033 General Acute Care Hospital (LTC wing) **Taxonomy Code: 282N00000X**										
011X 021X	Hospital Inpatient (Including Medicare Part A) Skilled Nursing Inpatient (Including Medicare Part A)	IP	70	LTC - Skilled	0110 - 0160*	General Room & Board Values	*If Recipient Has Medicare Part A* A2 - Eff. Date Of Medicaid A3 - Benefits Exhausted B3 - Benefits Exhausted - Payer B 22 - Date Active Care Ended 25 - Date Benefits Terminated	N/A	80	Covered Days
011X 021X	Hospital Inpatient (Including Medicare Part A) Skilled Nursing Inpatient (Including Medicare Part A)	IP	70	LTC - Skilled	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered

Provider Type 033 General Acute Care Hospital (LTC wing)
Taxonomy Code: 282N00000X

021X	Skilled Nursing Inpatient (Including Medicare Part A)	IP	**65	LTC Full Medicare Coverage	0110 - 0160*	General Room & Board Values		70	80	Covered Days
021X	Skilled Nursing Inpatient (Including Medicare Part A)	IP	**72	LTC-NF Skilled-Co-Ins(partial Medicare coverage)	0110 - 0160*	General Room & Board Values		70	82	Co Ins. Days
021X 022X	Skilled Nursing Inpatient (Including Medicare Part A) Skilled Nursing Facilities - (Inpatient Part B)	IP	38	Exceptional Care - TBI Level I Exceptional Care - TBI Level II Exceptional Care - TBI Level III Exceptional Care - VENT	0191 0192 0193 0194	Subacute Care - Level I Subacute Care - Level II Subacute Care - Level III Subacute Care - Level IV		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
079X	Clinic-Other	OP	083	Developmental Training	0942	Education/ Training		N/A		

Provider Type 038 Intermediate Care Facility, Mental Illness
Taxonomy Code: 310500000X

065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0110 - 0160*	General Room & Board Values		N/A	80	Covered Days
065X	Intermediate Care - Level I	IP	71	LTC - Intermediate	0182 0183 0185	Patient Convenience Therapeutic Leave Hospitalization		74	81	Non-Covered
					* Except for 0115, 0125, 0135, 0145 or 0155	1.				

Notes: ** When billing Medicare Covered services directly claim must include the Other Payer Loop showing the Medicare TPL code 909 and the Medicare adjudication information

The Occurrence Span Code (70) showing the Qualifying Stay is not required by HFS but can be reported on direct billed claims for Medicare Covered services

If Recipient Has Medicare Part A and Medicaid covered services are being billed an Occurrence Code showing Medicare benefit end date or Medicaid coverage begin date must be included on the claim

6. Enrollment, Eligibility and Disenrollment

Enrollment

Enrollment in Medicaid Programs
The Illinois Medical Assistance Program implements Title XIX of the Social Security Act (Medicaid). HFS administers Medicaid under the Illinois Public Aid Code. Through an inter-agency agreement with HFS, the Illinois Department of Human Services (DHS) takes applications and determines the eligibility of individuals and families for HFS medical programs.

To apply for HFS medical benefits, individuals, a representative, or their responsible parent or guardian must complete and submit an application to DHS. This can be done by visiting the nearest DHS office, or where health reasons prohibit visiting an office, by contacting DHS to have an application mailed. Mailed applications are followed by a telephone interview. It is also possible to enroll for HFS medical benefits through the DHS website.

DHS can be contacted at:

DHS website: http://www.dhs.state.il.us/page.aspx
Toll Free at: (800) 843-6154
TTY: (800) 447-6404

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.

Illinois Client Enrollment Services and HFS Health Plan Assignment
HFS clients who are among eligible populations and living in counties with authorized health plans are eligible to enroll and receive services from Molina. Clients must contact Illinois Client Enrollment Services (ICES) to select Molina as their health plan. Molina participates in the following HFS programs:
- HealthChoice Illinois Managed Long Term Services and Supports (MLTSS) - effective 1/1/2018
- HealthChoice Illinois - effective 1/1/2018
- Special Need Children – effective 2/1/2020

ICES can be contacted at:

ICES website: http://www.enrollhfs.illinois.gov/
Toll Free at: 1 (877) 912-8880:
TTY: (866) 565-8576

ICES assists eligible Medicaid enrollees with selecting a health plan of their choice. If enrollees do not choose a plan, ICES will passively assign the enrollee through auto assignment to a plan that services the area where the Member resides.

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

Effective Date of Enrollment

When initially applying for coverage, HFS applicants may request that their coverage is backdated to cover services they may have already received for up to three months prior to the month of their application. HFS will designate coverage to begin on the first day of a calendar month no later than three (3) calendar months from the date HFS accepts the enrollment in its database.

Newborn Enrollment

Enrollment of newborns, infants, and children who are added to the case of the mother whose RIN is on the IES transaction and who is enrolled with the Molina Healthcare, are enrolled automatically as follows:

- If the newborn is added to the case before the newborn is forty-six (46) days old, the newborn's effective enrollment date with Molina is retroactive to the newborn's date of birth.
- Molina will provide coverage of the newborn enrollee retroactively to the date of birth, based on the enrollment effective date determined by the Department.
- Molina will not require prior authorization for inpatient newborn claims for newborns retroactively enrolled pursuant to this section.

Enrollment of newborns, infants, and children who are added to the case of the mother whose RIN is on the IES transaction and who is enrolled with Molina, are enrolled automatically as follows: If an infant is added to the case after the age of forty-five (45) days and up to, but not including, one (1) year old, the newborn's effective enrollment date with Molina will be prospective. Molina will provide coverage of the infant enrollee prospectively, based on the effective enrollment date determined by the Department.

Children under the age of nineteen (19), excluding newborns and infants, who are added to the case of a sibling, mother, or head of household and whose RIN is on the IES transaction and who is enrolled with Molina, are enrolled automatically. Molina will provide coverage of the child enrollee prospectively.

For newborn claims where newborn has not yet been determined Medicaid eligible and assigned a RIN, Molina will follow the claims processing rules for newborns not yet assigned a RIN established by the department for fee-for-service claims.

Inpatient at time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge, the program or plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is no longer confined to an acute care hospital. Exception: This would not apply if the hospital is per diem.

Eligibility Verification

Medicaid Programs
HFS determines eligibility for Medicaid programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and Molina places the responsibility for eligibility verification on the provider of services.

Eligibility Listing for Medicaid Programs
HFS providers can verify eligibility and health plan assignment for HFS recipients through the Medical Electronic Data Interchange (MEDI) system. MCO health plan effective dates are *always the first of the month.*

MEDI is a free, secure website. Providers can register for MEDI and create their login and password at: http://www.myhfs.illinois.gov. Providers can also verify HFS eligibility and MCO health plan assignment on the phone by calling the HFS Automated Voice Response System at (800) 842-1461.

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

- Molina Member Services at (855) 687-7861
- Molina Web Portal at: https://provider.MolinaHealthcare.com/provider/login

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

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

Identification Cards
Molina Sample Member ID card

MOLINA HEALTHCARE — HealthChoice Illinois

Member:
<<Member_Name_1>>

Member ID: <<Member_ID_1>> Date of Birth: <<Date_of_Birth_1>> Effective Date: <<Member_effective_date_1>>

Primary Care Provider: <<PCP_name_1>>
PCP Address: <<PCP_Address_1>> <<TBD (for city,state,zip)>>
Primary Care Provider Phone: <<PCP_Phone_Number_1>>
RX Bin#: <<Bin_number_1>> RX PCN#. <<RxPCN_1>> RX Group: <<RxGroup1>>

Members:
To verify eligibility or change your Primary Care Provider (PCP) visit www.MyMolina.com or call Member Services **(855) 687-7861.** For hearing impaired, call the Illinois Relay at 7-1-1.
Emergency Services: Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your PCP or call our 24-Hour Nurse Advice Line at **(888) 275-8750** for English or **(866) 648-3537** for Spanish. For hearing impaired, call the Illinois Relay at 7-1-1.
Behavioral Health: 24-Hour Crisis Hotline (888) 275-8750. For Spanish dial (866) 648-3537.
Transportation: To schedule a ride or for day-of ride assist, call **(844) 644-6354.**
Providers: To verify eligibility, claims status or prior authorization, call **(855) 866-4562.**
Prior Authorization: Required for all inpatient admissions and selected outpatient services. Call **(855) 687-7861** to notify us of an admission.
Pharmacists: For pharmacy questions, call **(855) 866-5462.**
Dental: For any dental services, call Avesis Dental at **(866) 857-8124.**
Claim Submission: P.O. Box 540, Long Beach, CA 90801
EDI Submissions: Payor ID 20934
www.MyMolina.com

MOLINA HEALTHCARE — HealthChoice Illinois MLTSS

Member:
<<Member_Name_1>>

Member ID: <<Member_ID_1>> Date of Birth: <<Date_of_Birth_1>> Effective Date: <<Member_effective_date_1>>

Molina Healthcare does not assign primary care providers to MLTSS Members.

Members: To verify eligibility visit www.MyMolina.com or call Member Services **(855) 687-7861.** For hearing impaired, call the Illinois Relay at 7-1-1.
Emergency Services: Call 911 or go to the nearest emergency room or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your Primary Care Physician (PCP) or call our Nurse Advice Line at **(888) 275-8750** for English or **(866) 648-3537** for Spanish. For hearing impaired, call the Illinois Relay at 7-1-1.
Behavioral Health: 24-Hour Crisis Hotline (888) 275-8750. For Spanish dial (866) 648-3537.
Transportation: To schedule a ride or for day-of ride assist, call **(844) 644-6354.**
Providers: To verify eligibility, claims status or prior authorization, call **(855) 866-5462.**
Prior Authorization: Required for all inpatient admissions and selected outpatient services. Call **(855) 687-7861** to notify us of an admission.
Claim Submission: P.O. Box 540, Long Beach, CA 90801
EDI Submissions: Payor ID 20934
www.MyMolina.com

Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina 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
When an enrollee is subject to mandatory managed care enrollment under the Medicaid Managed Care Program, an enrollee may request to disenroll for cause for any of the following reasons at any time by notifying Molina, orally or in writing, of the enrollee's request to disenroll. The request will be granted by the Department when the reason matches any of the following (as determined by the Department):

- The enrollee moves out of the contracting area;
- Molina, due to its exercise of right of conscience, does not provide the covered service that the enrollee seeks;
- The enrollee needs related covered services to be performed at the same time, not all the related services are available through Molina, and the enrollee provider determines that receiving the services separately would subject the enrollee to unnecessary risk;
- When a change in enrollee's LTSS Provider (residential, institutional, or employment support) from a network provider to a non-network provider results in a disruption to residence or employment; or,
- Other reasons, including: poor quality of care; a sanction imposed by the Department; lack of access to covered services; lack of access to providers

experienced in dealing with the enrollee's healthcare needs; or if the enrollee is automatically re-enrolled and such loss of coverage causes the enrollee to miss the open enrollment period.

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

Involuntary Disenrollment

The Department will terminate an enrollee's coverage when the enrollee becomes ineligible for HFS Medical Program or otherwise is not within the population described as being enrollees under this contract, or upon the occurrence of any of the following conditions:

- Upon the enrollee's death. Termination of coverage will take effect at 11:59 p.m. on the last day of the month in which the enrollee dies. Termination may be retroactive to this date.
- When an enrollee elects to change MCOs during the change period or open enrollment period. Termination of coverage with the previous MCO will take effect at 11:59 p.m. on the day immediately preceding the enrollee's effective enrollment date with the new MCO.
- When an enrollee no longer resides in the contracting area. If an enrollee is to be disenrolled at Molina's request, Molina must first provide documentation satisfactory to the Department that the enrollee no longer resides in the contracting area. Termination of coverage will take effect at 11:59 p.m. on the last day of the month prior to the month in which the Department determines that the enrollee no longer resides in the contracting area. Termination may be retroactive if the Department is able to determine the month in which the enrollee moved from the contracting area.
- When the Department determines that an enrollee has other significant insurance coverage or is placed in spend-down status. The Department will notify Molina of such disenrollment. This notification will include the effective disenrollment date.
- When the Department is made aware that an enrollee is incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which the enrollee was incarcerated.
- When an enrollee enters DCFS custody. Termination of coverage shall take effect at 11:59 p.m. on the day prior to the day on which the court grants DCFS custody of the enrollee.

PCP Dismissal

A PCP may dismiss a Member from their practice based on standard, written office policies. PCPs must document the reasons for dismissal, which may include:

- A member who continues not to comply with a recommended plan of healthcare. Such requests must be submitted at least 60 calendar days prior to the requested effective date.
- A member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that their enrollment with the PCP seriously impairs the PCP's ability to furnish services to either the member or other patients. This section does not apply to members with mental health diagnoses if the member's behavior is attributable to the mental illness.

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

Missed Appointments

The provider will document and follow up on appointments missed and/or canceled by the member. Providers should notify Molina when a member misses two consecutive appointments. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel. Such a request must be submitted at least 60 calendar days prior to the requested effective date.

PCP Assignment

Illinois Client Enrollment Services (ICES) is responsible for all initial health plan and PCP assignments for HFS medical programs. HFS clients can voluntarily enroll in a health plan and select their PCP online at https://enrollhfs.illinois.gov/enroll or via phone at (877) 912-8880. HFS clients who do not select a health plan and PCP will have one chosen for them through auto assignment.

Molina will offer each Member a choice of PCPs. After making a choice, each Member will have a single PCP. 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. Providers shall advise all Members of the Members' responsibility to notify Molina and HFS of their pregnancies and the births of their babies.

The ICES will work to re-enroll a Member into the health plan in which he or she was most recently enrolled if the Member has a temporary loss of HFS eligibility, defined as less than 60 calendar days.

PCP Changes

Members may change their PCP designations at any time with the change being effective on the first day of the month following the date of the member's request.

Members who wish to change their PCP designations may call Molina Member Services at (855) 687-7861. Members may also manage their health care, anytime, via the Member portal available at www.MyMolina.com. Members may use the Member portal to change their PCP, update their contact information, request a new ID card, and view service history.

7. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link: https://www.molinahealthcare.com/members/il/en-US/PDF/Medicaid/member-handbook-healthchoice-illinois.pdf

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

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

For additional information, please contact Molina Healthcare at (855) 687-7861, 8 a.m. to 5 p.m., CST/CDT Monday to Friday, excluding state holidays. TTY users, please call 711.

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

8.   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. Applying medical necessity criteria review, and applying 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.

The table below outlines the key functions of the UM program. All prior authorizations are based on a specific standardized list of services

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

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact a 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; 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 (855) 866-5462 to obtain Molina's UM Criteria.

Medical Necessity
"**Medically Necessary**" or "**Medical Necessity**" means a service that is appropriate, no more restrictive than that used in the State Medicaid program, including quantitative or non-quantitation treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures, and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with Contractor's guidelines, policies, or procedures, for the diagnosis or treatment of a covered illness or injury; for the prevention of future disease; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; for the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the Enrollee's choice; or for an Enrollee to achieve age-appropriate growth and development.

This is for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:
1.   In accordance with generally accepted standards of medical practice;
2.   Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury or disease; and,
3.   Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in and of 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. Authorization is not a guarantee of payment.

Levels of Administrative and Clinical Review

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

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

The Clinical review includes medical necessity and level of care.

- Requested service is not experimental or investigation in nature.
- Servicing Provider can provide the service in a timely manner.
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition.
- Medical necessity criteria (according to accepted, nationally-recognized resources) is met.
- The service is provided at the appropriate level of care in the appropriate facility; e.g., outpatient versus inpatient or at appropriate level of inpatient care.
- Continuity and coordination of care is maintained.

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 web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
  o Pertinent medical history (include treatment, diagnostic tests, examination data).
  o Requested length of stay (for inpatient requests).
  o 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 forty-eight (48) 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 four (4) calendar days from receipt of the request.

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 full-time Medical Directors available to discuss Medical Necessity decisions with the requesting Provider by contacting the Utilization Management Department as indicated on the denial notification to schedule the call.

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 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 Request Form can be faxed to Molina at: (866) 617-4971.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services Department at (855) 866-5462. 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 Illinois
Attn: Healthcare Services Dept.
1520 Kensington Road Suite 212
Oak Brook, IL 60523

Molina has contracted with eviCore Healthcare (eviCore) to manage preauthorization requests for the following specialized clinical services:
- Imaging and Special Test
  - Advanced Imaging (MRI, CT, PET, Selected Ultrasounds)
  - Cardiac Imaging
- Radiation Therapy
- Sleep Covered Services and Related Equipment
- Genetic Counseling and Testing

Please refer to the Molina Prior Authorization Code Matrix located on the www.MolinaHealthcare.com website and contact eviCore by visiting the website: www.evicore.com and/or call phone number: (888) 333-8144.

Emergency Services

Emergency Services means: inpatient and outpatient healthcare services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish Emergency Services.

Emergency Medical Condition or Emergency means: a medical condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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.

Molina accomplishes this service by providing a twenty-four (24) hour Nurse Advise line after normal business hours, including weekends and holidays. 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.

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 determine the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification, medical necessity requirements or failure to include all the needed clinical documentation to support the

need for an inpatient admission may 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 for per diem hospitals.

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 denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Molina with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina's UM staff follow 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, along with taking into consideration any Social Determinants of Health.

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 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.

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 (855) 866-5462 during normal business hours, Monday through Friday (except for Holidays) from 8:00 a.m. to 5:00 p.m. Central Time. 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.

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 (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 are in need of 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 HCS 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 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.

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 866-5462.

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
Call the 24-hour Child Abuse Hotline at 800-25-ABUSE (800-252-2873 or TTY 1-800-358-5117) if you suspect that a child has been harmed or is at risk of being harmed by abuse or neglect. If you believe a child is in immediate danger of harm, call 911 first.

Adult Abuse
To report suspected abuse, neglect, or financial exploitation of an adult age 60 or older or a person with disabilities age 18-59 call the statewide, 24-hour **Adult Protective Services Hotline: (866) 800-1409, (888) 206-1327 (TTY).**

For residents who live in nursing facilities, call the Illinois Department of Public Health's Nursing Home Complaint Hotline: (800) 252-4343.

For residents who live in Supportive Living Facilities (SLFs), call the Illinois Department of Healthcare and Family Services' SLF Complaint Hotline: (800) 226-0768.

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.

Case Manager Responsibilities
The case manager collaborates with the Member and all resources involved in the Member's care to develop an ICP that includes recommended interventions from Member's interdisciplinary care team (ICT). ICP interventions include links to 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/authorized representative(s) 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.
- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

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

Health Education/Disease Management
Molina offers programs to help our Members and their families manage a diagnosed health condition. You as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. Our programs include:
- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management/Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD) management
- Depression management
- Obesity
- Weight Management
- Smoking Cessation
- Organ Transplant
- Serious and Persistent Mental Illness (SPMI) and Substance Use Disorder
- Maternity Screening and High Risk Obstetrics

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. The information may be phoned into, faxed or emailed to Molina using the information below:

- Phone: (855) 687-7861; Select Option 1
- Fax: (844) 479-5341
- Email: Quality-HealthCampaigns@MolinaHealthCare.com

For more info about our programs, please call: Provider Services Department at (855) 866-5462 (TTY/TDD at 711 Relay). Visit www.MolinaHealthcare.com.

Member Newsletters
Member Newsletters are posted on the www.MolinaHealthcare.com website at least (two) 2 times a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members are able to access our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, Members are directed to ask their doctor or visit our website, www.MolinaHealthcare.com.

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Identified Members will receive targeted outreach such as educational newsletters, telephonic outreach or other materials to access information on their condition. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and,
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

Contracted Providers are notified as appropriate, when their patients are enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and,
- Preventive Health Guidelines.

Additional information on health management programs is available from your local Molina HCS Department toll free at (855) 866-5462.

Care 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
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two (2) weeks of treatment
- Member accessing Emergency Department services inappropriately
- Children with Special Health Care Needs

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

Phone: (855) 866-5462
Fax: (855) 556-2073

9.   Provider Responsibilities

Non-discrimination of Healthcare Service Delivery
Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Medicaid website home pages. All Providers who join the Molina Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability, religion, genetic information, military status, ancestry, health status, sex, or need for health services. 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. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance with Medicare cost-sharing from a State Medicaid Program.

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

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
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 (some changes can be made online) at least thirty (30) days in advance, of changes such as, but not limited to:
- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition or termination of a Provider (within an existing clinic/practice)
- Change in practice name, Tax ID and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (PCPs only)
- Any other information that may impact Member access to care

Please visit our Provider Online Directory at 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 manager if your information needs to be updated or corrected.

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

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

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: EFT with ERA
- Provider Portal

Electronic Claims Submission Requirement
Molina requires participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider including:
- Promotes HIPAA compliance.
- Helps to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminates mailing time and enabling Claims to reach Molina faster.

Molina offers the following electronic Claims submission options:
- Submit Claims directly to Molina via the Provider Portal. See 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 20934, 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.

Electronic Payment (EFT/ERA) Requirement

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

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

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

Provider Portal

Providers 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 roster of assigned Molina members for PCP(s)
- Claims Functions
  - o Professional and Institutional Claims (individual or multiple claims)
  - o Receive notification of Claims status change
  - o Correct Claims
  - o Void Claims
  - o Add attachments to previously submitted Claims
  - o Check Claims status
  - o Export Claims reports
  - o Create and Manage Claim Templates
  - o Open Saved Claims
- Prior Authorizations/Service Requests
  - o Create and submit Prior Authorization/Service Requests
  - o Check status of Authorization/Service Requests
  - o Receive notification of change in status of Authorization/Service Requests
  - o Create Authorization/Service Request Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
  - o Create and submit a Claim Appeal
  - o Add Appeal attachments to Appeal
  - o 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 (or noncontracted providers) cannot bill the Member for any Covered Services . 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 of this Provider Manual.

Member Information and Marketing

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

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

Member Eligibility Verification

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

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

Member Cost Share

Under no circumstance will members be liable for any amount owed by Molina to the provider. Balance billing Molina members for services covered by Molina is prohibited. This includes asking members to pay the difference between the discounted and negotiated fees, and the provider's usual and customary fees. In addition, providers are

responsible for verifying eligibility and obtaining approval for services that require prior authorization.

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

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

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

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

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

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

Referrals
Network providers should have and maintain admitting privileges and, as appropriate, delivery privileges. In lieu of these privileges, the provider should have a written referral agreement with a network provider who has such privileges at a network hospital. The agreement must provider for transfer of medical records and coordination of care between physicians

A referral is necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient's medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Molina Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina except in the case of Emergency Services. For additional information please refer to the Healthcare Services section of this Provider Manual.

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

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

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

Participation in Quality Programs
Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:
- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews
- 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 Health Information and HIPAA Transactions
Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. For additional information please refer to the Compliance section of this Provider Manual.

Participation in Grievance and Appeals Programs
Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider

will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the Appeals and Grievances section of this Provider Manual.

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

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

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

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

10. Quality

Maintaining Quality Improvement Processes and Programs
Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality Department **toll free at** (855) 866-5462 or fax (855) 556-2074.

The address for mail requests is:

Molina Healthcare of Illinois, Inc.
Quality Department
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

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

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

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

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

Patient Safety Program
Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and case management/disease management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

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

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

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

Medical Records

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

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

Medical Record Keeping Practices

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

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

Content

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

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact;
- Legible signatures and credentials of Provider and other staff members within a paper chart;
- All Providers who participate in the Member's care;
- Information about services delivered by these Providers;
- Weight and height information, and as appropriate, growth charts
- A problem list that describes the Member's medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions (or notation that none are known);
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- Treatment plans that are consistent with diagnosis;
- A working diagnosis that is recorded with the clinical findings;
- Pertinent history for the presenting problem;
- Pertinent physical exam for the presenting problem;
- Lab and other diagnostic tests that are ordered as appropriate by the practitioner;
- Clear and thorough progress notes that state the intent for all ordered services and treatments;
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate;
- Notes from consultants if applicable;
- Up-to-date immunization records and documentation of appropriate history;
- All staff and Provider notes are signed physically or electronically with either name or initials;
- All entries are dated;
- All abnormal lab/imaging results show explicit follow up plan(s);
- All ancillary services reports;
- Documentation of all emergency care provided in any setting;
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report;
- Labor and Delivery Record for any child seen since birth;
- Family planning and counseling, obstetrical history and profile; and,
- A signed document stating with whom protected health information may be shared.

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

Retrieval
- The medical record is available to Provider at each Encounter.
- The medical record is available to Molina for purposes of quality improvement.
- The medical record is available to Illinois Department of Healthcare and Family Services 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 10 (ten) years.
- An established and functional data recovery procedure in the event of data loss.

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

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

Additional information on medical records is available from your local Molina Quality Department **toll free at** (855) 866-5462. See also the Compliance Section of this Provider Manual for additional information regarding HIPAA.

Access to Care
Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs

(adult and pediatric) and participating specialist (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on ninety percent (90%) availability for Emergency Services and ninety percent (90%) or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

Appointment Access

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

Medical Appointment Types	Standard
Routine preventive care	Within five (5) weeks from date of request
Routine preventive care for infant under 6 months	Within two (2) weeks from the date of request
Routine, symptomatic but not deemed serious	Within three (3) weeks from the date of request
Urgent Care	Within twenty-four (24) hours
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within three (3) weeks from the date of request (for complaints not deemed serious)
Urgent Specialty Care	Within twenty-four (24) hours
Initial Prenatal Visit – First Trimester	Within two (2) weeks from the date of request
Initial Prenatal Visit – Second Trimester	Within one (1) week from the date of request
Initial Prenatal Visit – Third Trimester	Within three (3) days from the date of request
Behavioral Health Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-life Threatening Emergency	Within six (6) hours
Urgent Care	Within twenty-four (24) hours
Routine Care	Within fourteen (14) calendar days
Follow-up Routine Care	Within 30 calendar days

Additional information on appointment access standards is available from your local Molina Quality Department **toll-free at** (855) 866-5462.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed sixty (60) minutes from appointment time, until the time seen by the PCP. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour telephone service, seven (7) days a week. The provider must have a published after-hours telephone number. This access may be through an answering service or other arrangements. Voicemail alone after hours is not acceptable.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the **Molina Provider Services Department toll free at (855) 866-5462 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 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 under the Resources tab on the Molinahealthcare.com website or from your local Molina Quality Department **toll free at (855) 866-5462.**

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.

Additional information on access to care is available under the Resources tab on the www.MolinaHealthcare.com website or is available from your local Molina Quality **Department toll free at (855) 866-5462.**

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 to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building,

accessibility of space within the office site, and ease of access for physically disabled patients.

Physical Appearance
The site visits includes, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of Waiting and Examining Room Space
During the site visit, Molina 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.
- 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 Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 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. In Illinois there are four (4) types of Advance Directives:

- **Healthcare Power of Attorney**: 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
- **Do-Not-Resuscitate Order (DNR):** a DNR is a medical order that says that cardiopulmonary resuscitation cannot be performed if the heart or breathing stops.
- **Mental Health Treatment Preference Declaration:** allows the member to state whether they want to receive electroconvulsive treatment or psychotropic medicine.

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

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

EPSDT Services to Enrollees Under Twenty-One (21) Years
Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services to Enrollees under twenty-one (21) years are timely according to required preventive guidelines. All Enrollees under twenty-one (21) years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905(R) of the Social Security Act. Molina's Improvement Department is also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

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. 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 the medical group notifying them of their results. Performance below Molina's standards may result in a CAP with a request the Provider submit a written corrective action plan to Molina within thirty (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs
Molina 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 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. 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 annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. CPGs are reviewed annually and are updated as new recommendations are published.

Molina CPGs 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
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Adult Preventative Care
- EPSDT for children from birth through age 20
- Smoking cessation
- Mental Health
- Psychotropic medication management
- Clinical pharmacy medication review
- Coordination of community support and services for Enrollees in HCBS waivers
- Dental services
- Pharmacy services
- Community reintegration and support
- Long Term Care (LTC) residential coordination of services
- Prenatal, obstetrical, postpartum, and reproductive healthcare

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, Just the Fax electronic 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 (855) 866-5462**.

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 & 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 USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers at www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

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

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

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

Molina's most recent results can be obtained from your local Molina Quality staff toll free at (855) 866-5462 or fax (855) 556-2074 or by visiting our website at www.MolinaHealthcare.com.

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 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 activities and health improvement programs. The

standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

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

Consumer Assessment of Healthcare Providers and Systems® (CAHPS)

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

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

Behavioral Health Survey

Molina obtains feedback from Members about their experience, needs, and perceptions of Members with 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, among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider Network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

11.   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, 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 at (855) 866-5462.

Nondiscrimination of Healthcare Service Delivery
Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website homepages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy, and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location 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.

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

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

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

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458

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, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities and assists Members with LEP.

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:
  o Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership, and,
  o Contracted Providers to assess gaps in network demographics.

- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health 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®/Qualified Health Plan Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- 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) 687-7861. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified 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. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

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

Members who are Deaf or Hard of Hearing
Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Healthcare Services and all other health plan functions.

Molina strongly recommends that Provider offices make 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 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 Member 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 TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

12. Compliance

Fraud, Waste, and Abuse

Introduction
Molina is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste and abuse. The plan also addresses fraud, waste and abuse prevention 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 plan to prevent, investigate and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

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

The term "knowing" is defined to mean that a person with respect to information:
* Has actual knowledge of falsity of information in the claim;
* Acts in deliberate ignorance of the truth or falsity of the information in a claim; or, Acts in reckless disregard of the truth or falsity of the information in a claim.

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

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

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

- The Federal False Claims Act and State Laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

The Federal False Claims Act and State Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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

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

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

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.

Stark Statute – Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care Providers.

Sarbanes-Oxley Act of 2002 – Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions
Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or

some other person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

Waste: means health care spending that can be eliminated without reducing the quality of care. Quality waste includes, overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g. coding) causing unnecessary costs to the Medicaid program.

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

Examples of Fraud, Waste and Abuse by a Provider
The types of questionable Provider schemes investigated by Molina include, but are not limited to the following:
- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.

- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

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

Review of Provider Claims and Claims System

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

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

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

Molina has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare 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 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 Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

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

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of

its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, 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 visit is appropriate.

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

Reporting Fraud, Waste and Abuse
If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 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 Illinois
Attn: Compliance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
Telephone: (888) 858-2156
Fax: (630) 571-1220

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

Suspected fraud and abuse may also be reported directly to the State at:
Illinois State Police
Medicaid Fraud Control Unit
8151 W. 183rd Street, Suite F
Tinley Park, Illinois 60477
Toll Free Phone: (844) 453-7283/ (844) ILFRAUD

Illinois Attorney General
Online at: https://www.illinois.gov/hfs/oig/Pages/ReportFraud.aspx

HIPAA Requirements and Information
HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy
Protecting the privacy of Members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all Federal and

State Laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

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

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

Applicable Laws

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

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

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

Uses and Disclosure of PHI

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

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

following situations:

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

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

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.

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

Patient Rights

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

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

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

HIPAA Transactions and Code Sets

Molina requires the use of electronic transactions to streamline health care administrative activities. Molina Providers must submit Claims and other transactions to Molina using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

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

Molina 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. 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 Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review

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

MOLINA HEALTHCARE OF ILLINOIS, INC.

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

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

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

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

   _____
   _____
   _____

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

   _____
   _____
   _____

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

   _____
   _____
   _____

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

   _____
   _____
   _____

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes_____ No_____

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

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

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

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

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

    a. action has been taken in reliance on this authorization; or,

    b. if this authorization is obtained as a condition of obtaining health care coverage, other Law provides the Health Plan with the right to contest a Claim under the benefits or coverage under the plan.

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

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

    _____

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

_____   _____
Signature of Member or Member's Personal   Date
Representative

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

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

13.   Claims and Compensation

As a contracted Provider, it is important to understand how the Claims process works to avoid delays in processing your Claims. The following items are covered in this section for your reference:
- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- Claims Disputes/Reconsiderations
- Billing the Member
- Fraud and Abuse
- Encounter Data

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

The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):
1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a)   Fractures
    b)   Dislocations
    c)   Intracranial Injuries
    d)   Crushing Injuries
    e)   Burn
    f)   Other Injuries
6. Manifestations of Poor Glycemic Control
    a)   Hypoglycemic Coma
    b)   Diabetic Ketoacidosis
    c)   Non-Ketotic Hyperosmolar Coma
    d)   Secondary Diabetes with Ketoacidosis

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

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

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

Claim Submission
Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or Molina's Provider Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 20934. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

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

Required Elements
The following information must be included on every claim:
- Member name, date of birth and Molina Member ID number.

- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification number (TIN).
- 10-digit National Provider Identifier (NPI).
- Rendering Provider name as applicable.
- Billing/Pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location information.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

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

Electronic Claims Submission
Molina strongly encourages participating Providers to submit Claims electronically, including secondary claims. Electronic Claims submission provides significant benefits to the Provider including:
- Helps to reduce operation costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Molina faster.

Molina offers the following electronic Claims submission options:
- Submit Claims directly to Molina via the Provider Portal.
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 20934.

Provider Portal
Molina's Provider Portal offers a number of claims processing functionalities and benefits:
- Available to all Providers at no cost.
- Available twenty-four (24) hours per day, seven (7) days per week.
- Ability to add attachments to claims (Provider Portal and clearinghouse submissions).

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

Clearinghouse
Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

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

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

EDI Claims Submission Issues
Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@MolinaHealthcare.com for additional support.

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

> Molina Healthcare of Illinois, Inc.
> P.O. Box 540
> Long Beach, CA 90806

Please keep the following in mind when submitting paper claims:
- Paper claims should be submitted on original red colored CMS 1500 claims forms.
- Paper claims must be printed, using black ink.

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

COB
Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment

information is required with the Claim submission. Providers can submit Claims with attachments, including explanation of benefits (EOBs) and other required documents, by utilizing Molina's Provider Portal. Providers can also submit this information through EDI and Paper submissions.

TPL

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

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

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

Molina utilizes a claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:
- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare and Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more

stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
  - o In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
  - o In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
  - o CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

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

CPT and HCPCS Codes
Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers
Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:
- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

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

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

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

Type of Bill
Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC's) Official UB-04 Data Specifications Manual.

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

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

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

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

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

Coding Sources

Definitions
CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:
- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

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

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

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

Provider acknowledges Molina's right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

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

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

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

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

Corrected Claims

Corrected Claims 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 30 days after receipt of Clean Claims.

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

Electronic Claim Payment

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

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 90 days of Molina's original remittance advice date. All request received after this time will be denied for untimely filing.

Molina providers may use one of the following options for submission of a claim appeal or dispute:

- **Provider Web Portal**: Providers may submit their appeals and disputes along with supporting documentation through Molina's Provider Web Portal. The Provider Web Portal can be accessed on the Molina provider home page at www.MolinaHealthcare.com
- **Fax**: A Claims Dispute Request Form is required when submitting via fax. The completed Claims Dispute Request Forms along with supporting documentation may be faxed to Molina at: (855) 502-4962. The Claims Dispute Request Form may be accessed on Molina's website at: www.MolinaHealthcare.com/providers/il/PDF/Medicaid/Claims_Dispute_Request_Form.pdf

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

The Provider will be notified of Molina's decision in writing within 30 days of receipt of the Claims Dispute/Adjustment request.

Billing the Member
- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
  - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
  - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
  - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse
Failure to report instances of suspected Fraud and Abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Provider Manual for more information.

Encounter Data
Each Provider, capitated Provider, or organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within thirty (30) 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 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.

14. 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.

Types of Practitioners Credentialed & Recredentialed
Practitioners and groups of Practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

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

- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

Uniform Credentialing and Recredentialing
In accordance with 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and recredentialing process. To participate in Molina's Provider network, Molina must verify that Practitioner is enrolled in IMPACT. Molina will submit monthly reports to the Illinois Department of Healthcare and Family Services indicating which Practitioners have completed the credentialing process and the results of the process.

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 meets all criteria for initial participation and continued participation in the Molina network. If the Practitioner fails provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

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

attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments.

- **License, Certification or Registration** – Provider must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located, and the State the Member is located.

- **DEA or CDS Certificate** – Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a Practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the practitioner is not eligible to participate in the Molina network.

- **Specialty** – Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Molina Members.

- **Education** –Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.

- **Residency Training** – 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)

- o American Board of Podiatric Medicine (ABPM)
- o American Board of Oral and Maxillofacial Surgery
- o American Board of Addiction Medicine (ABAM)
- o College of Family Physicians of Canada (CFPC)
- o Royal College of Physicians and Surgeons of Canada (RCPSC)
- o Behavioral Analyst Certification Board (BACB)
- o 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 body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.

- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.

- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.

- **Professional Liability Insurance** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.

- **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

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[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.

privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.

- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare 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 credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification, sanctions or exclusions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 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 at PO Box 2470, Spokane, WA 99210

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing Department will notify the Practitioner.

If the Practitioner does not respond within 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.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than sixty (60) calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

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

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions
Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality are identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare 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.

15. Provider Claim Dispute, Provider Complaint, Enrollee Appeal and Grievance Process

Provider Claim Dispute Process

A request to review the processing, payment or non-payment of a claim by Molina shall be classified as a Provider Claim Dispute and can be submitted through one of the following options:

- **Web Portal**: Providers are strongly encouraged to use the Molina Web Portal to submit Provider Claims Disputes.
- **Fax**: Provider Claims Disputes can be faxed to Molina at: (855) 502-4962. Must also contain a completed Claims Dispute Form.

    NOTE: CD's containing medical records may be sent to: Molina Healthcare of Illinois, Attention Provider Disputes, 1520 Kensington Rd., Suite 212, Oak Brook, IL 60523. Must include a completed Claims Dispute Form.

A contracted provider may request reconsideration of a claim on his or her behalf by submitting a completed Claims Dispute Form with supporting documentation as appropriate. The Claims Dispute Form must be completed to document the review request. The Claim Dispute Form is located online at www.MolinaHealthcare.com for providers by utilizing the "Forms" link.

All provider reconsiderations for payment or non-payment must be submitted to Molina within ninety (90) calendar days from the date of original remittance advice. All requests received after this timeframe will be denied for untimely filing. An upheld resolution letter will be sent to the provider.

To dispute timely filing providers must submit documentation to support their timely filing. Acceptable documentation of timely filing is a signed receipt by Molina staff for registered postal or commercial delivery system.

Molina will have sixty (60) business days to process a claims related dispute or reconsideration request. All requests submitted without appropriate documentation will be denied for lack of information. The provider will be responsible for providing the appropriate requested documentation within ninety (90) calendar day from the original remittance date. Molina or regulatory agency may request medical records during reconsideration process and the provider shall not charge the Enrollee or Molina for requested records submitted for the reconsideration.

Provider Complaints

Providers have the right to file a complaint if they are dissatisfied with any aspect of operation or service rendered by Molina that **does not** pertain to a benefit or claim determination. Complaints may be submitted no later than thirty 30 calendar days from the date the provider becomes aware of the issue generating the complaint. Provider complaints can be mailed to Molina at the following address:

Molina Healthcare of Illinois, Inc.
Attn: Provider Complaints Dept.

1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Or Via Fax: (855) 502-4962

Enrollee Appeals Processes
Molina Enrollees or the personal representatives of Enrollees have the right to file a grievance and submit an appeal through a formal process. All appeals must first be submitted to Molina within sixty (60) days from the Adverse Benefit Determination. Appeals not resolved wholly in the enrollees favor can be appealed to the Illinois Department of Healthcare and Family Services (HFS). However, the filing of an appeal does not preclude the Enrollee from filing a complaint with HFS.

This section addresses the identification, review and resolution of Enrollees appeal. Below are Molina's Enrollees Appeals Process.

Appeals may be submitted by Enrollees or an authorized representative, such as a family Member or their Provider on behalf of the enrollee in response to an Adverse Benefit Determination. If the appeal is submitted by someone other than the Enrollee a signed Molina Healthcare of Illinois Authorized Representative Designation form must be included with submission. If Molina's decision is to deny a service in whole or part, Enrollees and providers are notified of the following at the time of denial:

- Their right to appeal the decision
- The process by which the appeal process is initiated
- The Molina customer service phone number where more information regarding the appeal process can be obtained
- The availability of the Illinois State Department of Insurance

Medical Coverage Member Appeals with eviCore Healthcare on Selected Services
Molina has contracted with eviCore Healthcare (eviCore) to manage preauthorization requests for the following specialized clinical services:
- Imaging and Special Tests
  - Advanced Imaging (MRI, CT, PET, Select Ultrasounds)
  - Cardiac Imaging
- Radiation Therapy
- Sleep Covered Services and Related Equipment
- Genetic Counseling and Testing

For medical coverage member appeals of the above services, contact eviCore for 1st level pre-service appeals:
eviCore healthcare
Attn: Clinical Appeals
400 Buckwalter Place Blvd
Bluffton, SC 29910
Fax: 1-866-699-8128
Or email appeals@evicore.com

Enrollee Type of Appeals

An Enrollee may request an expedited appeal, or standard appeal. Standard appeals may be filed orally or in writing and are requesting to change an adverse determination for care or services submitted by the enrollee or their authorized representative within sixty (60) days from the Adverse Benefit Determination notice.

An Expedited appeal request is submitted to the plan for review of an Adverse Benefit Determination if waiting the standard appeal timeframe such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the individual in (or, with respect to a pregnant women, the health of the women or her unborn child) serious jeopardy
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part

Enrollee Authorized Representative

An Enrollee may appoint an Authorized Representative to act on their behalf. The representative may be a guardian, caretaker, relative, health care provider, or an attorney. Any standard appeals requested on behalf of the Enrollee, must have the written authorization from the Enrollee. The Enrollee is required to complete an Authorized Representative Designation Form and send the form to Molina with the appeal request. Molina can provide the form as needed.

If an Authorized Representative is filing on behalf of an Enrollee an Authorized Representative Designation Form must be completed and signed by the Enrollee within fifteen (15) days of the receipt of the appeal. Lack of written consent does not pose any barrier to the Enrollee's appeal process; however, if it is not received within the timeframe, the appeal request will be closed, and the Enrollee will be notified that the appeal was closed with no determination as the authorization form was not received.

Molina will ensure that no punitive action is taken against a provider who acts as an authorized representative on behalf of the Enrollee, or supports an appeal filed by an Enrollee.

Enrollee Standard Appeals Process and Timeline

Standard appeals may be received orally or in writing within sixty (60) calendar days following the date of the notice of action. An oral appeal request may be filed by calling Molina's Customer Service department. However, all oral appeals must be followed up with a written request signed by the Enrollee. Standard appeal requests submitted in writing should be sent to the address or fax number below:

Molina Healthcare of Illinois, Inc.
Attn: Enrollee Appeals and Grievance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Or Via Fax: (855) 502-5128

All appeal requests must include the Enrollee's name, address, Enrollee's number, reasons for appealing, and documentation or evidence such as medical records, physician letters, or other important information that explains the reason the service or item is needed. An Authorized Representative Form should be attached to the request when appropriate on behalf of an Enrollee. An appeal request submitted after the 60-day timeframe must provide good cause in order for Molina to consider the late request such as, the Enrollee being seriously ill preventing the ability to file the appeal.

Upon receipt of an appeal, Molina will notify the party filing the appeal, of all information that is required to evaluate the appeal. A written acknowledgement will be sent to the Enrollee.

Molina will render a decision on the appeal within fifteen (15) business days after receipt of the written appeal request. Molina will notify the party filing the appeal, the Enrollee or authorized representative of the Enrollee, PCP, and any health care provider who recommended the service involved in the appeal orally of its decision. Oral notification will be followed up by a written notice of determination.

If the Enrollee or authorized representative filing the appeal is dissatisfied with Molina's determination, an External Independent Review or a State Medicaid hearing may be requested. No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

Written notifications of the appeal decision will contain reasons for the determination including the medical or clinical criteria used to make the determination.

If the Enrollee is dissatisfied with the outcome of an appeal, the Enrollee or authorized representative may request an External Independent Review for non-waiver services.

Enrollees who are not satisfied with Molina's resolution of any appeal may request a State Hearing with the Illinois Department of Healthcare and Family Services (HFS) at the following location if they are part of the Health Choice of Illinois.

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearing
69 W. Washington, 4th Floor.
Chicago, IL 60602

Fax: (312) 793-2005

Or you may call (855) 418-4421

For hearing impaired, TTY at (800) 526-5812

HFS may also be contacted electronically at http://www.hfs.illinois.gov

Enrollees who are not satisfied with Molina's resolution of an appeal may request a State Hearing with the Illinois Department of Human Services (DHS) at the following location if the Members are part of the Persons with Disabilities, Persons with Traumatic

Brain Injury (TBI), or Persons with HIV/AIDS waiver populations contained within Health Choice of Illinois Service Package II:

Illinois Department of Human Services
Bureau of Fair Hearings
69 W. Washington, 4th Fl.
Chicago, IL 60602

Fax: (312) 793-2005

Or you may call (855) 418 4421

For hearing impaired, TTY at (800) 526-5812

Enrollee Expedited Internal Appeals Process and Timeline
Expedited appeals may be received orally or in writing within sixty (60) days from the date of the notice of action. Any requests submitted in writing should be sent to the address or fax number noted above under the Standard Appeal process section. Expedited appeal requests on behalf of the Enrollee do not require signed written consent of the Enrollee. A request to expedite an appeal will be considered in situations where applying the standard appeal timeframe could seriously jeopardize the Enrollee's life, health or ability to regain maximum function. An expedited review is not possible when services have already been provided to the Enrollee.

Upon receipt of appeal, Molina will notify the party filing the appeal as soon as possible, and within no more than twenty-four (24) hours after receipt, of all information that is required to evaluate the appeal.

Molina will render a decision within twenty-four (24) hours after receiving the required information. If additional information required to make the final appeal determination is not received within seventy-two (72) hours, a determination will be made with the current information available.

If it is determined the expedited appeal request does not meet expedited criteria the request will be processed under the standard appeal timeframe of fifteen (15) business days from the date the request was received.

Molina will notify the party filing the appeal, the Enrollee (or designated representative) the Enrollee's PCP, the requesting provider, and any health care provider who recommended the service involved in the appeal orally of its decision. Oral notification will be followed up by a written notice of determination within two (2) calendar days following the oral notification.

Enrollee External Independent Review
An external independent review may be requested by a non-waiver Enrollee or authorized representative or either orally or in writing.

Requests for External Independent Review must be submitted within thirty (30) days of receipt of written notification of a denied appeal. Written requests must be accompanied

by any information or documentation to support the Enrollee's request for covered service or claim for a covered service.

Molina will do the following for External Independent Review:
- Molina will forward all medical records and supporting documentation, with a description of the applicable issues, and a statement of Molina's decision along with the criteria used and medical and clinical reasons for the decision to the external independent reviewer. The External Independent Reviewer will evaluate and analyze the case and render a decision for all standard requests. The decision by the independent review is final. If the reviewer determines the health care service to be medically appropriate, Molina will pay for the service. Molina will notify the requestor orally and in writing of the results of the external independent review.
- The external independent reviewer will not be informed of the specific identity of the Enrollee.
- The external independent reviewer must be a clinical peer and have no direct affiliation to Molina or financial interest in connection with the case in question.

Enrollee Expedited External Independent Review
A request for an expedited independent review may be made orally or in writing. Molina will review the information and notify the requestor within twenty-four (24) hours of receipt of the request of information if it meets the criteria for an expedited timeframe that a standard timeframe could seriously risk the Enrollee's life or health. Molina will ensure all external independent reviews are determined as expeditiously as possible, and no later than twenty-four (24) hours from receipt of the required information. If additional information is required to make the final appeal determination and it is not received within seventy-two (72) hours, a determination will be made with the current information available. Molina will notify the requestor orally of the results of the expedited external independent review within twenty-four (24) hours after receipt of the required information. Written notification will be sent within two (2) calendar days from the date the decision was made.

Enrollee Continuation of Benefits
Enrollees may file for a continuation of benefits on or before the latter of ten (10) days from the Adverse Benefit Determination, or the intended Effective Date of the proposed Adverse Benefit Determination. Molina will continue the Enrollee's benefits during the Appeal process. A provider, serving as the Enrollee's authorized representative for the Appeal process, cannot file for continuation of benefits.

Illinois Department of Healthcare and Family Services (HFS) Review
Enrollees not satisfied with the determination of the external independent reviewer may request a State Hearing. Parties to the review include Molina and the Enrollee (or authorized representative).

Requests for HFS review must be filed within one hundred twenty (120) days after the date of the Appeal Decision Letter. The request must be sent to HFS at the following address:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings

69 W. Washington, 4th Fl.
Chicago, IL 60602

Fax: (312) 793-2005

Or you may call (855) 418-4421

For hearing impaired, TTY at (800) 526-5812

HFS may also be contacted electronically at http://www.hfs.illinois.gov

Second Opinion
If an Enrollee wishes to obtain a second opinion on the care they receive or plan to receive for covered health care services, they may do so from an in-network provider at no cost. An Enrollee can call Member Services to find out how to get a second opinion at no cost to the Enrollee. Health Choice of Illinois (855) 687- 7861. Members can call (855) 766- 5462; TTY: 711, Monday-Friday, 8:00 a.m. - 5:00 p.m.

Enrollee Grievance Process
Molina has an organized grievance process to ensure thorough, appropriate and timely resolution to Enrollees' grievances. A grievance is an expression of dissatisfaction which may include but are not limited to:
- Requests for disenrollment
- Difficulty finding a provider
- Unhappy with the prior authorization process
- Services provided by Molina staff or Molina providers

If an Enrollee is unhappy with Molina or its providers, they may file a grievance by contacting Member Services. They can also write to us at:

Molina Healthcare of Illinois, Inc.
Attn: Appeals and Grievance
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523

Or via fax: (855) 502- 5128

Enrollees are notified of their grievance through various general communications including, but not limited to, the Member Handbook, Evidence of Coverage and Disclosure, Member newsletters and Molina's website.

Enrollees may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance. If under applicable law, a person has authority to act on behalf of an Enrollee in making decisions related to health care or is a legal representative of the Enrollee, Molina will treat such person as a personal representative. Providers are permitted to submit a grievance on behalf of Enrollee. However, signed consent from the Enrollee is required. Molina will ensure that no punitive action is taken against a provider who acts as an

authorized representative on behalf of the Enrollee or supports a grievance filed by an Enrollee.

When needed, Enrollees are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Enrollees with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) is referred to the Quality Improvement (QI) Department for documentation and further investigation when appropriate. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health.

Information (PHI) is referred to the Privacy Officer.

Enrollee Grievance Timelines
An Enrollee may file a grievance of the incident or following the date the Enrollee was made aware of the incident. A written acknowledgement of the grievance is sent to the Enrollee within forty-eight (48) hours from receipt. A determination will be made as expeditiously as possible but no later than ninety (90) days from receipt of the Grievance. Molina will provide the Enrollee (or designated representative) notification of outcome.

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

Appeals and Grievances will be reported to the State quarterly.

Record Retention
Molina will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via the Appeals and Grievances log or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. Provider shall request and obtain Molina's prior approval for the disposition of records if agreement is continuous.

MLTSS Program Appeals, Grievances, and State Hearings
Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased and appropriate resolutions. Molina MLTSS Members, or their

authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina ensures that Members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

16. 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. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA© accredited or certified in Credentialing functions or demonstrate an 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 completed on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files,

Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

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 a Credentialing Pre Delegation survey, 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.