Provider Manual

Molina Healthcare of Wisconsin Inc.
Medicaid Provider Reference Manual
Effective 10/01/2018

Table of Contents

Welcome!

Dear Provider:

Welcome to Molina Healthcare of Wisconsin, Inc. Enclosed is your Medicaid Provider Manual, written specifically to address the requirements of delivering healthcare services to Molina Healthcare Members.

This Manual is designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this manual. In these instances, you do not need to change your procedures as long as they adhere to the standards outlined in this Manual.

From time to time, this Manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the Molina Healthcare website as they occur. All contracted Providers will receive an updated Provider Manual annually, which will be made available at MolinaHealthcare.com.

Thank you for your active participation in the delivery of quality healthcare services to Molina Healthcare Members.

Sincerely,

Scott R. Johnson
President
Molina Healthcare of Wisconsin, Inc.

Section 1. Contact Information

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's) and Member complaints. Member Services Representatives are available 8:00am to 5:00pm Monday through Friday, excluding State holidays.

The Interactive Voice Response (IVR) system can also be accessed for certain inquiries and is available twenty-four (24) hours per day, seven (7) days per week. Information available from the IVR system includes Member eligibility, PCP name verification, and primary insurance carrier information, submission of Referral request, submission of prior Authorization requests, Referral status check, prior Authorization status check and Claim status check.

Member Services
Address: Molina Healthcare of Wisconsin, Inc. PO Box 242480 Milwaukee, WI 53224
Phone: 888-999-2404
TTY: 7-1-1 for the National Relay Service
IVR: 888-999-2404
Website: MolinaHealthcare.com

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 Service Representatives who serve all of Molina Healthcare of Wisconsin's Provider Network.

Provider Services
Address: Molina Healthcare of Wisconsin, Inc. PO Box 242480 Milwaukee, WI 53224
Phone: 855-326-5059
Fax: 877- 556- 5863
TTY: 7-1-1 for the National Relay Service
IVR: 888-999-2404
Website: MolinaHealthcare.com

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

Claims Recovery	
Address:	Molina Healthcare of Wisconsin, Inc. P.O. Box 2470 Long Beach, CA 90801
Phone:	855-326-5059

Credentialing Department
The Credentialing Department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina Healthcare network.

Credentialing	
Address:	Molina Healthcare of Wisconsin, Inc. PO Box 242480 Milwaukee, WI 53224
Phone:	855-326-5059
Fax:	877-556-5863
E-mail:	WisconsinCredentialing@Molinahealthcare.com

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

HEALTHLINE (24·Hour Nurse Advice Line)	
Phone:	888-275-8750 (English) 866-648-3537 (Español)
TTY:	7-1-1 for the National Relay Service

Member Advocate
Members are able to contact a Member Advocate using the contact information below.

Member Advocate	
Phone:	888-999-2404

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

Utilization Management **Authorizations and Inpatient Census**
Phone: 855-326-5059
Fax: 877-708-2117
The Utilization Management Department is available to answer questions from 8:00 a.m. to 5:00 p.m., Monday through Friday. After business hours a voicemail can be left and calls will be returned the next business day.

Health Management Level 1 and Health Management Department
Molina Healthcare'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.

Health Management Level 1 Programs
Phone: 866-472-9483
Fax: 562-901-1176

Health Management
Phone: 866-891-2320
Fax: 800-642-3691

Behavioral Health
Molina Healthcare of Wisconsin, Inc. manages all components of our covered services for behavioral health. For Member behavioral health needs, please contact us directly at:

Behavioral Health
Address: Molina Healthcare of WI, Inc. PO Box 242480 Milwaukee, WI 53224
Phone: 855-326-5059
Fax: 877-708-2117
(24) Hours per day, (365) day per year: English: (888) 275-8750 TTY: (866)735-2929 Spanish: (866) 648-3537 TTY: (866) 833-4703

Claims Submission

Claim status can be checked on Molina Healthcare's Provider Self-Services Web Portal at Provider.MolinaHealthcare.com, through the 24-Hour Automated Phone System, or by contacting Molina Healthcare Member Services.

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

- Access the Provider Portal (Provider.MolinaHealthcare.com)
- EDI Payer ID ABRI1.

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions contact Provider Services at 855 326-5059.

Dental and Vision services are provided through vendors, and claims should be submitted directly to those vendors as follows:

Vision Claims
Address: Herslof Optical Company Inc. 12000 W. Carmen Avenue Milwaukee, WI 53225

Dental Claims
Address: Molina Healthcare of Wisconsin Claims P.O. Box 2136 Milwaukee, WI 53201

Section 2. Benefits and Covered Services

Molina Healthcare follows Medicaid rules except where there are rules specific to a physician network or Participating Provider. Some benefits may have limitations. Providers should refer to the most current benefits grid available from Molina Healthcare by visiting the website at MolinaHealthcare.com and choosing the provider tab for the State of Wisconsin. In 2014, Molina Healthcare of Wisconsin, Inc. Members have $0 copayments for all Covered Services.

Prescription Drugs (Pharmacy and Supplies)
Pharmacy and disposable medical supplies (supplied by pharmacies) provided to Medicaid recipients are not administered through Molina Healthcare. This is a carved out service that is handled through Fee-For-Service (FFS).

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 Healthcare. More information about our Prior Authorization process, can be obtained by contacting Molina Healthcare at 855-326-5059.

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

Non-Emergency Medical Transportation
Non-Emergency Medical Transportation (NEMT) services are currently coordinated by FFS for Wisconsin Medicaid or BadgerCare Plus members in both Fee-For-Service and Medicaid Health Maintenance Organization (HMO) health plans. Members will need to call the vendor for all NEMT to covered appointments if they have no other way to get a ride. Non-emergency rides are rides to a Covered Service by common carrier, such as public transportation or specialized medical vehicles.

Members can call 1-866-907-1493 (or TTY 1-866-288-3133) between 7:00 a.m. and 6:00 p.m., Monday through Friday.

Members will need to call at least two (2) days before a routine appointment to schedule a ride. If they do not call two (2) days before an appointment, they may have to reschedule their appointment.

If a Member has an urgent appointment and cannot wait two (2) days to go to an appointment, a ride may be scheduled within three (3) hours.

If a Member has regularly scheduled appointments three (3) or more times a week, the provider should talk with him/her. As the Member's doctor, the provider can work with the transportation vendor to help schedule his/her patient's regularly reoccurring rides.

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

Chiropractic Services
Molina Healthcare of Wisconsin, Inc. does not cover chiropractic services. All Members receive chiropractic Services through the Wisconsin Fee- For- Service (FFS) program.

Molina Healthcare of Wisconsin, Inc. Members who receive chiropractic coverage through Fee- For- Service (FFS) can go anywhere their ForwardHealth card is accepted. FFS claims are submitted and paid through the State of Wisconsin.

Vision Care
Molina Healthcare of Wisconsin, Inc. subcontracts with Herslof Optical Company, Inc. to provide routine vision services and hardware including any prior Authorization necessary and Claims payment.

24·Hour Nurse Advice Line
Members may call the Nurse Advice 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.

The Nurse Advice Line 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 the Member back to the PCP, a Specialist, 911 or the ER. By educating patients, it reduces costs and overutilization of the health care system.

Behavioral Health: Mental Health and Substance Abuse Benefits
Molina Healthcare offers benefit programs to BadgerCare Plus and Medicaid SSI enrollees. The following levels of care are covered, provided that services are Medically Necessary, delivered by Participating Providers, and that the Authorization procedures are followed:

- Inpatient Detoxification
- Substance Abuse Rehabilitation
- Inpatient Mental Health
- Traditional Outpatient Mental Health Treatment
- Traditional Outpatient Substance Abuse Treatment
- Crisis Stabilization Bed
- Partial Hospital Program
- Intensive Outpatient Program
- Ambulatory Detoxification
- Psychological and Neuropsychological Testing
- In-Home Therapy for Children

Access to Behavioral Health Services
Molina Healthcare of Wisconsin, Inc. provides all of its Members with behavioral health services. Please contact Molina Healthcare of Wisconsin, Inc. directly for Behavioral Health Services needs at 855-326-5059.

Outpatient Benefits Access
Outpatient behavioral health treatment is an essential component of a comprehensive health care Delivery System. Members may access outpatient mental health and substance abuse services by self-referring to a

Participating Provider, by calling Molina Healthcare, or by Referral through acute or emergency room encounters. Members may also access outpatient care by Referral from their PCPs. However, a PCP Referral is not required by Molina Healthcare-for behavioral health services. Additionally, providers may check the ForwardHealth website for updates regarding outpatient benefits.

Additional Benefit Information
Benefits do not include payment for health care services that are not Medically Necessary. Molina Healthcare is not responsible for the costs of investigational drugs or devices. Molina Healthcare is not responsible for the costs of non-health care services such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the Member's care.

Lab Work
Any associated lab work allowed on Molina Healthcare of Wisconsin, Inc.'s in-office lab list may also be coded separately.

Multiple Procedures
Modifier 51 is required for Claim processing when multiple procedures are performed on the same date. If modifier 51 is not appended to the CPT's after the primary procedure then those CPT's will be denied.

Coordination of Benefits (COB)
Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare 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 Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare 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. Provider can submit claims with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal.

Timely Filing with Other Insurance
Timely filing for Participating Providers is sixty (60) days from the date on the remit from the primary payer unless otherwise stated in the provider's contract. The EOB from the primary payer is required with Claim submission.

Provider Web Portal
Molina Healthcare of Wisconsin, Inc. implemented a Web Portal specifically for its providers to be able to access some of Molina Healthcare's helpful tools for their office.

The Web Portal provides access to the following information:
- **PCP Roster –** Rosters for Molina Healthcare's Primary Care Providers
- **Service Request/Authorization –** Helps provider to create, save, submit and check the status of a Service Request/Authorization form in real time.
- **Member Eligibility –** Quickly and easily search for Members and see if they are currently eligible with a few simple steps.
- **Claims –** Perform Claim status inquiries, create, save and submit professional Claims.

Providers can register by visiting: MolinaHealthcare.com.

Section 3. 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 been 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)
6) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
7) 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

8) Catheter-Associated Urinary Tract Infection (UTI)
9) Vascular Catheter-Associated Infection
10) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
11) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
12) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
13) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
14) Iatrogenic Pneumothorax with Venous Catheterization
15) 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 provide 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, 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: ABRI1**.**

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 for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

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 requires Participating Providers to submit Claims electronically. 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 ABRI1

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 (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

If electronic submission is not possible, please submit paper claims to the following address:
Molina Healthcare of Wisconsin, Inc.
P.O. Box 22815
Long Beach, CA 90801

Coordination of Benefits and Third Party Liability

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare 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 Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare 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 EOBs and other required documents, by utilizing Molina's Provider Portal.

Third Party Liability

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina Healthcare 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 any and 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 180 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

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, and 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, and 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 Wisconsin and Federal requirements and also administers payment rules based on generally accepted principles of correct coding. Payment rules based on generally accepted principles of correct coding include, but are not limited to, the following:

- Manuals and 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 Wisconsin the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCDs).
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
  - CMS Physician Fee Schedule Relative Value File (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.
- Forward Health Processing guidelines
- 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 Wisconsin and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Fee Schedule Updates

Molina applies BadgerCare Plus and/or Medicaid SSI fee-for-service rates effective for the 1st of the month

following the receipt by Molina of the fee-for-service rate file from WI DHS. Neither rates nor claims will be adjusted on a retrospective basis, regardless of whether DHS sets a retrospective rate. Molina does not retroactively load fee schedules with the exception of the New Year January fee schedule which will be dated to be effective for January 1 of that year.

Provider Preventable Conditions

Molina Healthcare of Wisconsin does not make payment for provider preventable conditions in alignment with Medicaid contract requirements.

Molina Healthcare shall mandate provider identification of provider preventable conditions as a condition of payment, as well as, the prohibition against payment for provider-preventable conditions as set forth in 42 CFR s.434.6(a)(12) and 42 CFR s. 447.26. Molina Healthcare will report all identified provider-preventable conditions through its encounter data.

Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis(DVT)/Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.

Other provider-preventable conditions for non-payment are identified as:

- Wrong surgical invasive procedure performed on the wrong body part;
- Surgical or other invasive procedure performed on the wrong patient.

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

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's 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. 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.

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. **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 MolinaHealthcare.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, 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

Providers disputing a Claim previously adjudicated must request such action within 90 days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Appeals Form found on the Provider website and the Provider web-portal. *The form must be filled out completely in order to be processed*. Additionally, the item(s) being resubmitted should be clearly marked as an appeal and must include the following:

A. Provider's name.
B. Date of service.
C. Date of billing.
D. Date of payment and/or Nonpayment.
E. Member's name.
F. Claim number- Services cannot be appealed without a claim on file.
G. BadgerCare Plus ID number.
H. The reason(s) the claim merits reconsideration. If the appeal relates to medical emergency, medical necessity and/or prior authorization, medical records or substantiating documentation must accompany your request for reconsideration.
I. The Claim number clearly marked on all supporting documents

Appeals MUST be submitted via fax, secure e-mail or the Provider Portal (preferred method). Paper appeals will be rejected and not processed.

- **Bulk appeals (10 claims or more for the same issue)** must be e-mailed and include an excel spreadsheet that includes data for A-G, a completed appeal form and supporting documentation.

Provider Appeals	
Fax:	844-251-1446
Secure E-mail:	MWIAppeals@MolinaHealthcare.com
Provider Portal (preferred):	Provider.MolinaHealthcare.com

The Provider will be notified of Molina's decision in writing within 45 days of receipt of the Claims Dispute/Adjustment request.

All BadgerCare Plus providers must appeal first to the HMO and then to the Department of Health Services if they disagree with the HMO's payment or nonpayment of a Claim.

Appeals to the Department of Health Services (DHS) must be submitted using DHS form F12022 and all elements of the form must be completed at the time the form is submitted (i.e. Medical Records for Appeals regarding Medical Necessity). The form is available on the ForwardHealth Portal. Appeals to DHS must be made within sixty (60) days of Molina Healthcare of Wisconsin Inc.'s final decision or in the case of no response, within sixty (60) days from the forty-five (45) day time allotted to Molina Healthcare of Wisconsin, Inc. to respond. DHS Appeals should be mailed to: Forward Health Managed Care Appeals, P.O. Box 6470, Madison, WI 537I6-0470. DHS has thirty (30) days from the date of receipt of all written comments to inform the provider and Molina Healthcare of Wisconsin, Inc. of the final decision. If the decision of DHS is in the provider's favor, Molina Healthcare of Wisconsin, Inc. will pay the Claim within thirty (30) days of receipt of the final determination.

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 capitated Provider/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, 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. For institutional services, only those services covered by Molina should be reported.

Molina shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

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 will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction

Section 4. Complaints, Grievance and Appeals Process

Member Complaints/Grievances

Each Molina Health Plan has a process in place to investigate Provider-specific complaints from Members upon their receipt. Molina evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six months.

Complaints

Molina Healthcare has a simplified process whereby Members can register Complaints which are logged and recorded by Molina Healthcare. These Complaints are resolved without the filing of a formal Appeal or Grievance.

The resolution of a Member Complaint does not preclude the Member from access to review of a formal Appeal or Grievance.

Complaints can be made by contacting Molina Healthcare Member Services at 888-999-2404. If the initial Complaint is received via phone call, the call is logged in the call tracking system by the Member Services Representative (MSR). The MSR either handles the situation or refers the caller to the appropriate department or person who can better resolve his/her particular situation. Members are informed during the call of the procedure to follow if they wish to file a formal Appeal or Grievance. They must submit it in writing. Callers are also offered the assistance of the Member Advocate or the Member Inquiry and Resolution Coordinator if they need help writing their letter.

Grievances and Complaints

All Grievances and Appeals, whether oral or written, are documented and logged by the Member Services Department in all appropriate systems. Members are notified of their Grievance and Appeals rights and the different levels of Grievances and Appeals through various general communications including, but not limited to, the Member Handbook, Member newsletters and Molina Healthcare's website: MolinaHealthcare.com.

Members may identify an individual, including an attorney or provider, to serve as an Authorized Representative to act on their behalf at any stage during the Grievance and Appeals process. If under applicable law, a person has authority to act on behalf of a Member in making a decision related to health care or is a legal representative of the Member, Molina Healthcare of Wisconsin, Inc. will treat such person as an Authorized Representative.

Molina Healthcare will not take any punitive actions against any provider who represents a Member with regard to a filed Grievance or Appeal.

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

Members will continue receiving any and all benefits during the Grievance and Appeals process unless they have previously dis-enrolled.

Subcontractors may resolve some Complaints, but communication to the Member related to Grievances and Appeals must involve Molina Healthcare's Appeals and Grievances Department.

Filing a Grievance

If a Member is unhappy with the service from Molina Healthcare or providers contracted with Molina Healthcare, he/she may file a Grievance by contacting Member Services toll-free at 888-999-2404. Members can also write to Molina Healthcare at:

Grievances & Complaints	
Address:	Molina Healthcare of Wisconsin, Inc. Attn: Grievances/ Complaints Dept. PO Box 242480 Milwaukee, WI 53224-9050
Fax:	844-251-1446

Molina Healthcare of Wisconsin, Inc. has an organized Grievance process to ensure thorough, appropriate and timely resolution to Members' Grievances and to aggregate and trend reasons for Grievances in order to take action to reduce future occurrence. Grievance documentation will include the following factors:

- The substance of the Grievance and actions taken.
- The investigation of the substance of the Grievance, including any aspects of clinical care involved.
- The outcome/resolution.

• The documentation of notification to the Member of the disposition of the Grievance and the right to appeal, as appropriate.

Written acknowledgement of a Grievance received is sent to the Member or his/her Authorized Representative within ten (10) days of receipt. A resolution letter is sent within thirty (30) days of initially receiving the Grievance unless the Member is notified in writing of the need for an additional fourteen (14) day extension, along with the reason for the delay. The Member is notified of his/her right to request a hearing at Molina Healthcare and that the Member may attend or send representation for him/her to the hearing. The Member is also notified that interpretation would be provided free of charge should he/she decide to exercise this option.

In the case of an Expedited Grievance, a determination is made and the Member is notified within two (2) business days.

Member Appeals

An Appeal may be filed by a Member, Member's Authorized Representative or a provider. The Member or Authorized Representative must be a party to all Appeals.

Appeals may be oral or written. Oral Appeals must be followed by a written request, except when a provider requests an Expedited Appeal. Written requests should be submitted to:

Member Appeals	
Address:	Molina Healthcare of Wisconsin, Inc. Attn: Member Appeals Department PO Box 242480 Milwaukee, WI 53224
Fax:	844-251-1446
E-mail:	MWIAppeals@MolinaHealthcare.com

Written acknowledgement of an Appeal received is sent to the Member or his/her Authorized Representative within ten (10) days of receipt. A resolution letter is sent within thirty (30) days of initially receiving the Appeal unless the Member is notified in writing of the need for an additional fourteen (14) day extension, along with the reason for the delay. The Member is notified of his/her right to request a hearing at Molina Healthcare and that the Member may attend or send representation for him/her to the hearing. The Member is also notified that interpretation would be provided free of charge should he/she decide to exercise this option.

In the case of Expedited Appeals, a determination is made and the Member is notified within two (2) business days.

If the appealing party is dissatisfied with the outcome of an Appeal, A State Fair Hearing may be requested.

Proposed Actions

When Members and providers are notified of Molina Healthcare's proposed Action in connection to a requested health care service or Claim for service, they are also notified of the following:

- The proposed Action Molina Healthcare has taken or intends to take.
- The reasons for the Action.
- Their right to appeal the decision.
- The process by which the Appeals process is initiated.
- The Molina Healthcare Member Services phone number where more information regarding the Appeals process can be obtained.
- The circumstances under which an expedited review is available and how to request it.
- The Member's right to have benefits continue pending resolution of the Appeal with Molina Healthcare, or with the State Fair Hearing, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay for these benefits.

Notifications of proposed Actions are mailed to Members as expeditiously as reasonably possible.

Adverse Action
Notifications of Adverse Actions will be sent to the Member in his/her primary language and will include the following information:

- The results and date of the Adverse Action.
- The right to request a State Fair Hearing within forty-five (45) days of the determination, and information on how to do so.

- The Member's right to continue benefits if a State Fair Hearing is requested and how to do so.
- Information on the circumstances under which the Member may be liable for the cost of continued benefits.

State Fair Hearings
Members who are not satisfied with Molina Healthcare's final resolution of any Appeal may further appeal the decision to the State by requesting a State Fair Hearing. Requests for a hearing must be made in writing within forty-five (45) days from the date the notice of Adverse Action is mailed. Written requests should be submitted to the DHS at the following location:

Department of Administration Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Molina Healthcare will make available any records or witnesses for State Fair Hearings at no expense to the Member/provider.

Section 5. Credentialing and Re-credentialing

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.

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 of Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Definitions

A Rental/Leased Network - a network of Providers that leases its panel to another network or insurer with an emphasis on expanding Provider access and negotiating discounted fee-for-service fees. This type of network is sometimes referred to as a brokerage-leased network or thought of as "wholesale," since Members' access to the network is through an intermediary.

Primary Care Provider (PCP) – a Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to Pediatricians, Family Providers, General Providers or Internists, as designated by Molina.

General Practitioner – Physicians who are not Board Certified and have not completed a training program from an accredited training program in their requested specialty.

Urgent Care Provider (UCP) - a Provider who is not a PCP and only provides urgent care services to Members. Urgent care services are medically necessary services, which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

Primary Source verification - the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credential to the Provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician bills and receives payment for the substitute physician as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

Physician – is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

Unprofessional conduct - refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct, which is reasonably likely to be detrimental to Patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina plan.

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 Providers for participation in the Molina network. 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 Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina. These criteria and the sources used to verify these criteria are listed in the table below.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Providers who do not meet the criteria. Molina may, after considering the recommendations of the Credentialing 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 Provider to a hearing or any other rights of review.

Providers must meet the following criteria to be eligible to participate in the Molina network. If the Provider fails to meet/provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Application Provider must submit to Molina a complete, signed and dated credentialing application. The application must be typewritten or completed in non-erasable ink. Application must include all required attachments. The Provider must sign and date the application attesting their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. **If the Provider's attestation exceeds one-hundred-eighty (180) days before**	▪ Every section of the application is complete or designated N/A ▪ Every question is answered ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision ▪ All required attachments are present ▪ Every professional question is clearly answered and the page is completely legible ▪ A detailed written response is included	All Provider types	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
the credentialing decision, the Provider must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the Provider to update the attestation. If Molina or the Credentialing Committee requests any additional information or clarification, the Provider must supply that information in the period requested. Any changes made to the application must be initialed and dated by the Provider. Whiteout may not be used on the application rather the incorrect information must have a line drawn through it with the correct information written/typed and must be initiated and dated by the Provider. If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina does not consider the associated attestation elements as present if the	for every yes answer on the professional questions			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Provider did not attest to the application within the required period of one-hundred-eighty (180) days. If State regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation. The application and/or attestation documents cannot be altered or modified.				
License, Certification or Registration Provider must hold an active, current 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. If a Provider has ever had his or her professional license/certification/registration in any State suspended or revoked or Provider has ever surrendered, voluntarily or involuntarily, his or her professional license/certification/registration in any State while under or to avoid investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct, Molina will verify all licenses,	Verified directly with the appropriate State licensing or certification agency. This verification is conducted by one of the following methods: ▪ On-line directly with licensing board ▪ Confirmation directly from the appropriate State agency. The verification must indicate: ▪ The scope/type of license ▪ The date of original licensure ▪ Expiration date ▪ Status of license ▪ If there have been, or currently are, any disciplinary action or sanctions on the license.	All Provider types who are required to hold a license, certification or registration to practice in their State	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
certifications and registrations in every State where the Provider has practiced.				
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 Provider has a pending DEA/CDS certificate because of just starting practice or because of moving to a new State, the Provider may be credentialed on "watch" status provided that Molina has a written prescription plan from the Provider. This plan must describe the process for allowing another Provider with a valid DEA/CDS certificate to write all prescriptions requiring a DEA/CDS number. If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS certificate, the Provider may be considered for network participation if they submit a prescription plan for another Provider with a valid DEA or CDS certificate to write all prescriptions.	DEA or CDS is verified by one of the following: ▪ On-line directly with the National Technical Information Service (NTIS) database. ▪ On-line directly with the U.S. Department of Justice Drug Enforcement Administration, Office of Diversion Control ▪ Current, legible copy of DEA or CDS certificate ▪ On-line directly with the State pharmaceutical licensing agency, where applicable Written prescription plans: ▪ A written prescription plan must be received from the Provider. It must indicate another Provider with a valid DEA or CDS certificate to write all prescriptions requiring a DEA number. ▪ Molina must primary source verify the covering Providers DEA.	Physicians, Oral Surgeons, Nurse Providers, Physician Assistants, Podiatrists	Must be in effect at the time of decision and verified within one-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
If a Provider does not have a DEA because it has been revoked, restricted or relinquished due to disciplinary reasons, the Provider is not eligible to participate in the Molina network.				
Education & Training Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore, Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.	As outlined below under Education, Residency, Fellowship and Board Certification.	All Provider Types	Prior to credentialing decision	Initial & Recredentialing
Education Provider must have graduated from an accredited school with a degree required to practice in their specialty.	The highest level of education is primary source verified by one of the following methods: ▪ Primary source verification of Board Certification as outlined in the Board Certification section of this policy. ▪ Confirmation from the State licensing agency when Molina has documentation that the State agency conducts primary source verification of the highest level of education and this confirmation is not greater than 12-months old. ▪ The American Medical Association	All Provider types	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	(AMA) Physician Master File. This verification must indicate the education has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the education has specifically been verified. ▪ Confirmation directly from the accredited school. This verification must include the type of education, the date started, date completed and if the Provider graduated from the program. ▪ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. ▪ Association of schools of the health professionals, if the association performs primary-source verification of graduation from medical school and Molina has written confirmation from the association that			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ If a physician has completed education and training through the AMA's Fifth Pathway program, this must be verified through the AMA. ▪ Confirmation directly from the National Student Clearing House. This verification must include the name of the accredited school, type of education and dates of attendance.			
Residency Training Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Verification of the residency is always required except for General Providers as described in the General Provider section below. Molina only recognizes residency 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	Residency Training is primary source verified by one of the following methods: ▪ Primary source verification of current or expired board certification in the same specialty of the Residency Training program (as outlined in the Board Certification section of this policy). ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. ▪ The American Osteopathic	Oral Surgeons, Physicians, Podiatrists	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed 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.	Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified. ▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed. ▪ Association of schools of the health professionals, if the association performs primary-source verification of residency training and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old. ▪ For Closed Residency Programs, residency completion can be verified through the Federation of State Medical Boards Federation			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	Credentials Verification Service (FCVS). ▪ For podiatrists, confirmation directly from the Council of Podiatric Medical Education (CPME) verifying podiatry residency program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed.			
Fellowship Training If the Provider is not board certified in the specialty in which they practice and has not completed a residency program they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing. When a Provider has completed a Fellowship, Molina always completes either a verification of Board Certification or Verification of Residency in addition to the verification of Fellowship to meet the NCQA requirement of verification of highest level of training.	Fellowship Training is primary source verified by one of the following methods: ▪ Primary source verification of current or expired Board Certification in the same specialty of the Fellowship Training program (as outlined in the Board Certification section of this policy). ▪ The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile	Physicians	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	Report or AOA Physician Master File. This verification must indicate the training has specifically been verified. ▪ Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed.			
Board Certification Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not board certified may 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)	Board certification is primary source verified through one of the following: ▪ An official ABMS (American Board of Medical Specialties) display agent, where a dated certificate of primary-source authenticity has been provided (as applicable). ▪ AMA Physician Master File profile (as applicable). ▪ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File (as applicable). ▪ Confirmation directly from the board. This verification must include the specialty of the	Dentists, Oral Surgeons, Physicians, Podiatrists	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
▪ American Board of Podiatric Medicine (ABPM) ▪ American Board of Oral and Maxillofacial Surgery ▪ American Board of Addiction Medicine (ABAM) Molina must document the expiration date of the board certification within the credentialing file. If the board certification does not expire, Molina must verify a lifetime certification status and document in the credentialing file. American Board of Medical Specialties Maintenance of Certification Programs (MOC) –Board certified Providers that fall under the certification standards specified that board certification is contingent upon meeting the ongoing requirements of MOC, no longer list specific end dates to board certification. Molina will list the certification as active without an expiration date and add the document in the credentialing file.	certification(s), the original certification date, and the expiration date. ▪ On-line directly from the American Board of Podiatric Surgery (ABPS) verification website (as applicable). ▪ On-line directly from the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM) website (as applicable). ▪ On-line directly from the American Board of Oral and Maxillofacial Surgery website www.aboms.org (as applicable). ▪ On-line directly from the American Board of Addiction Medicine website https://www.abam.net/find-a-doctor/ (as applicable).			
General Practitioner Providers who are not board certified and have not completed a training program from an accredited training program are only eligible	The last five years of work history in a PCP/General practice must be included on the application or curriculum vitae and must include the	Physicians	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
to be considered for participation as a general Provider in the Molina network. To be eligible, the Provider must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Provider who is/was board certified and/or residency trained to participate as a general Provider, if the Provider is applying to participate in one of the following specialties : ▪ Primary Care Physician ▪ Urgent Care ▪ Wound Care	beginning and ending month and year for each work experience. Any gaps exceeding six months will be reviewed and clarified either verbally or in writing. Verbal communication will be appropriately documented in the credentialing file. A gap in work history that exceeds 1 year will be clarified in writing directly from the Provider.			
Advanced Practice Nurse Providers Advanced Practice Nurse Providers must be board certified or eligible to become board certified in the specialty in which they are requesting to practice. Molina recognizes Board Certification only from the following Boards: ▪ American Nurses Credentialing Center (ANCC) ▪ American Academy of Nurse Providers Certification Program (AANP) ▪ Pediatric Nursing Certification Board (PNCB)	Board certification is verified through one of the following: ▪ Confirmation directly from the board. This verification must include the specialty/scope of the certification(s), the original certification date, and the expiration date. ▪ Current copy of the board certification certificate including the specialty/scope of the certifications(s), the original certification date and the expiration date	Nurse Providers	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
▪ National Certification Corporation (NCC)	▪ On-line directly with licensing board, if the licensing primary verifies a Molina recognized board certification. License must indicate board certification/scope of practice. ▪ Provider attests on their application to board certification including the specialty/scope of the certifications(s), the original certification date and the expiration date.			
Physician Assistants Physician Assistants must be licensed as a Certified Physician Assistant. Physician Assistants must also be currently board certified or eligible to become board certified the National Commission on Certification of Physician Assistants (NCPPA).	Board certification is primary source verified through the following: ▪ On-line directly from the National Commission on Certification of Physician Assistants (NCPPA) website https://www.nccpa.net/.	Physician Assistants	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing
Providers Not Able To Practice Independently In certain circumstances, Molina may credential a Provider who is not licensed to practice independently. In these instances it would also be required that the Provider providing the supervision and/or oversight be contracted and credentialed with Molina. Some examples of these types of Providers include:	▪ Confirm from Molina's systems that the Provider providing supervision and/or oversight has been credentialed and contracted.	Nurse Providers, Physician Assistants and other Providers not able to practice independently according to State law	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
▪ Physician Assistants ▪ Nurse Providers				
Work History Provider must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the Provider has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse Provider, clinical social worker) within the 5 years should be included. If Molina determines there is a gap in work history exceeding six-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina determines there is a gap in work history that exceeds one-year, the Provider must clarify the gap in writing.	The credentialing application or curriculum vitae must include at least 5-years of work history and must include the beginning and ending month and year for each position in the Provider's employment experience. If a Provider has had continuous employment for five years or more, then there is no gap and no need to provide the month and year; providing the year meets the intent. Molina documents review of work history by including an electronic signature or initials of the employee who reviewed the work history and the date of review on the credentialing checklist or on any of the work history documentation.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Malpractice History Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of	▪ National Provider Data Bank (NPDB) report	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
malpractice and professional liability claims and settlement history is requested from the Provider 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 Provider.				
State Sanctions, Restrictions on licensure or limitations on scope of practice Provider must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider 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 Provider. Molina will also verify all licenses, certifications and registrations in every State	▪ Provider must answer the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The appropriate State/Federal agencies are queried directly for every Provider and if there are any sanctions, restrictions or limitations, complete documentation regarding the action will be requested. ▪ The NPDB is queried for every Provider.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
where the Provider has practiced. At the time of initial application, the Provider must not have any pending or open investigations from any State or governmental professional disciplinary body.[1]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.				
Medicare, Medicaid and other Sanctions Provider 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. Provider 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 Provider. Provider must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the	▪ The HHS Inspector General, Office of Inspector General (OIG) is queried for every Provider. ▪ Molina queries for State Medicaid sanctions/exclusions /terminations through each State's specific Program Integrity Unit (or equivalent). In certain circumstances where the State does not provide means to verify this information and Molina has no way to verify State Medicaid sanctions/exclusions /terminations. ▪ The System for Award Management	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

[1] If a Provider's application is denied solely because a Provider 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 Provider may reapply as soon as Provider 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 (1) year from the date of original denial.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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 Provider.	(SAM) system is queried for every Provider. ▪ The NPDB is queried for every Provider.			
Professional Liability Insurance Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria as stated below unless otherwise stated in addendum B. This coverage shall extend to Molina Members and the Providers activities on Molina's behalf. **The required limits are as follows:** **Physician (MD,DO) Nurse Provider, Certified Nurse Midwife, Oral Surgeon, Physician Assistant, Podiatrist =** $1,000,000/$3,000,000 **All non-physician Behavioral Health Providers, Naturopaths, Optometrists =** $1,000,000/$1,000,000 **Acupuncture, Chiropractor, Massage**	A copy of the insurance certificate showing: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage ▪ Either the specific Provider name or the name of the group in which the Provider works ▪ Certificate must be legible Current Provider application attesting to current insurance coverage. The application must include the following: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional	All Provider types	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Therapy, Occupational Therapy, Physical Therapy, Speech Language Pathology = $200,000/$600,000	liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage Providers 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. A copy of the Federal tort or self-insured letter or an attestation from the Provider showing active coverage are acceptable. Confirmation directly from the insurance carrier verifying the following: ▪ Name of commercial carrier or statutory authority ▪ The type of coverage is professional liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage			
Inability to Perform Provider must disclose any inability to perform essential functions of a Provider in their area of	▪ Provider must answer all the related questions on the credentialing application.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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 Provider. An inquiry regarding inability to perform essential functions may vary. Molina may accept more general or extensive language to query Providers about impairments.	▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision			
Lack of Present Illegal Drug Use Provider must disclose if they are currently using any illegal drugs/substances. An inquiry regarding illegal drug use may vary. Providers may use language other than "drug" to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully	▪ Provider must answer all the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If the Provider discloses they are currently participating in a substance abuse monitoring program, Molina will verify directly with the applicable substance abuse monitoring program to ensure the Provider is compliant in the program or has successfully completed the program. ▪ The attestation must	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
participating in a substance abuse monitoring program or successfully completing a program.	be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision			
Criminal Convictions Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Provider must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.	▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If there are any yes answers to these questions, and the crime is related to healthcare, a national criminal history check will be run on the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Loss or Limitation of Clinical Privileges Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.	▪ Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ The NPDB will be queried for all Providers. ▪ If the Provider has had disciplinary action related to	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	clinical privileges in the last five (5) years, all hospitals where the Provider has ever had privileges will be queried for any information regarding the loss or limitation of their privileges.			
Hospital Privileges Providers must list all current hospital privileges on their credentialing application. If the Provider has current privileges, they must be in good standing. Providers may choose not to have clinical hospital privileges if they do not manage care in the inpatient setting.	The Provider's hospital privileges are verified by their attestation on the credentialing application stating the Provider has current hospital admitting privileges.	Physicians and Podiatrists	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Medicare Opt Out Providers 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.	CMS Medicare Opt Out is queried for every Provider. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years and may not be contracted with Molina for any Medicare or Duals (Medicare/Medicaid) lines of business.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
NPI Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).	▪ On-line directly with the National Plan & Provider Enumeration System (NPPES) database.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
SSA Death Master File	▪ On-line directly with	All Providers	One-	Initial &

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Providers must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File. If a Provider's Social Security number is listed on the SSA Death Master File database, Molina will send the Provider a conflicting information letter to confirm the Social Security number listed on the credentialing application was correct. If the Provider confirms the Social Security number listed on the SSA Death Master database is their number, the Provider will be administratively denied or terminated. Once the Provider's Social Security number has been removed from the SSA Death Master File database, the Provider can reapply for participation into the Molina network.	the Social Security Administration Death Master File database.		hundred-eighty (180) Calendar Days	Recredentialing
Review of Performance Indicators Providers going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators.	Written documentation from the Molina Quality Department and other departments as applicable will be included in all recredentialing files.	All Providers	One-hundred-eighty (180) Calendar Days	Recredentialing
Denials	▪ Confirmation from	All Providers	One-hundred-	Initial

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Providers denied by the Molina Credentialing Committee are not eligible to reapply until one (1) year after the date of denial by the Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation.	Molina's systems that the Provider has not been denied by the Molina Credentialing Committee in the past 1-year.		eighty (180) Calendar Days	Credentialing
Terminations Providers terminated by the Molina Credentialing Committee or terminated from the Molina network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation.	▪ Confirm from Molina's systems that the Provider has not been terminated by the Molina Credentialing Committee or terminated from the Molina network for cause in the past 5-years.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Administrative denials and terminations Providers denied or terminated administratively as described throughout this policy are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation.	▪ Confirmation from Molina's systems if a Provider was denied or terminated from the Molina network, that the reason was administrative as described in this policy.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Employees of Providers denied, terminated, under investigation or in the Fair Hearing Process Molina may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been	When a Provider is denied or terminated from network participation or who is under investigation by Molina, it will be verified if that Provider has any employees. That information will be reviewed by the Credentialing Committee and/or Medical Director and a determination will be	All Providers	Not applicable	Initial and Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina. Molina also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina. For purposes of these criteria, a company is “owned” by a Provider when the Provider has at least five percent (5%) financial interest in the company, through shares or other means.	made if they can continue participating in the network.			

Burden of Proof

The Provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a Provider without limitation, including physical and mental health status as allowed by Law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina network. If the Provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Provider Termination and Reinstatement

If a Provider’s contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement, if there is a break in service more than thirty (30) calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the Provider's reentry into the network. Not all elements require re-verification; for example,

graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than thirty (30) calendar days, the Provider can be reinstated without being initially credentialed.

If Molina is unable to recredential a Provider within thirty-six (36) months because the Provider is on active military assignment, maternity leave or sabbatical, but the contract between Molina and the Provider remains in place, Molina will recredential the Provider upon his or her return. Molina will document the reason for the delay in the Provider's file. At a minimum, Molina will verify that a Provider who returns has a valid license to practice before he or she can resume seeing Patients. Within sixty (60) calendar days of notice, when the Provider resumes practice, Molina will complete the recredentialing cycle. If both party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

Providers Terminating with a Delegate and Contracting with Molina Directly

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with Molina or wish to contract with Molina directly must be credentialed by Molina within six (6) months of the Provider's termination with the delegate. If the Provider has a break in service more than thirty (30) calendar days, the Provider must be initially credentialed prior to reinstatement.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider must attest that their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina may use another organization's application as long as it meets all the factors. Molina will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The application must include, unless State law requires otherwise:

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and,
- The correctness and completeness of the application.

The Process for Making Credentialing Decisions

All Providers requesting participation with Molina must complete a credentialing application. To be eligible to submit an application, Providers must meet all the criteria outlined above in the section titled "Criteria for Participation in the Molina Network". Providers requesting initial credentialing may not provide care to Molina Members until the credentialing process is complete and final decision has been rendered.

Molina recredentials its Providers at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, the Provider's application will be downloaded from CAQH (or a similar NCQA© accepted online applications source), or a request will be sent to the Provider requesting completion of a recredentialing application.

During the initial and recredentialing application process, the Provider must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last one-hundred-eighty (180) calendar days
- Provide Molina adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network.

Once the application is received, Molina will complete all the verifications as outlined in the Molina Credentialing Program Policy. In order for the application to be deemed complete, the Provider must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina must be provided.

If the Provider does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina network. Providers who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process, each credentialing file is assigned a level based on the guidelines below. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Credentialing Committee. The Medical Director has the right to request the Credentialing Committee review any credentials file. The Credentialing Committee has the right to request to review any credentials file.

Process for Delegating Credentialing and Recredentialing

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina's requirements for delegation. Molina's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina's requirements.
Molina's Credentialing Committee retains the right to approve new Providers and Provider sites and terminate Providers, Providers and sites of care based on requirements in the Molina Credentialing Policy. To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA)© accredited or certified for credentialing or pass Molina's credentialing delegation pre-assessment, which is based on NCQA© credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least ninety percent (90%).
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Molina as described in policy and procedure.
- Comply with all applicable Federal and State Laws.
- If the IPA or Provider Group sub-delegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA© certified in all ten areas of accreditation.

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 or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the Provider specializes. This does not preclude Molina from including in its network Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Prevention

Molina takes appropriate steps to protect against discrimination occurring in the credentialing and recredentialing processes. Molina maintains a heterogeneous credentialing committee Membership. It is also required that each committee Member signs an affirmative statement annually to make decisions in a nondiscriminatory manner.

Notification of Discrepancies in Credentialing Information

Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license, malpractice claims history or sanctions. 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. Please also refer to the section below titled 'Providers Right to Correct Erroneous Information'.

Notification of Credentialing Decisions

A letter is sent to every Provider with notification of the Credentialing Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the Provider's credentials files. Under no circumstance will notification letters be sent to the Providers later than sixty (60) calendar days from the decision.

Confidentiality and Immunity

Information regarding any Provider or Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under this Policy and Procedure. Confidentiality shall also extend to such information that is provided by third parties.
For purposes of this section a "Representative" shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a Provider's or Provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or Provider's provision of patient care services.
By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the Provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal Claims against any representative who acts in accordance with the provisions of this policy and procedure.

3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider;
2. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and Claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina operations and actions relating to Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by; Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant State and Federal Law, and are not a limitation thereof.

All Members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by Law. Access to these documents are restricted to authorized staff, Credentialing Committee Members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three (3) months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable Laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Staff is instructed not to divulge passwords to their co-workers.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The Provider 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 Provider 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 Provider are documents which the Provider sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the Provider credentialing checklist, the responses from monitoring organizations (i.e. National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

Providers Right to Correct Erroneous Information

Providers have the right to correct erroneous information in their credentials file. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received. Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license or malpractice claims history. 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.

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

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the Provider must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Provider's response must be sent to:

Molina Healthcare, Inc.
Attention: Credentialing Director
PO Box 2470
Spokane, WA 99210.

Upon receipt of notification from the Provider, Molina will document receipt of the information in the Provider'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 Provider's credentials file. The Provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with Providers', the Credentialing Department will notify the Provider. The Provider may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the Provider does not respond within ten (10) calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application. Providers applying for initial participation are sent a letter when their application is received by Molina and are notified of their right to be informed of the status of their application in this letter.

The Provider can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two working days. Molina may share with the Provider where the application is in the credentialing process to include any missing information or information not yet verified.

Molina does not share with or allow a Provider to review references or recommendations, or other information that is peer-review protected.

Credentialing Committee

Molina designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina works with the Credentialing Committee to strive to assure that network Providers are competent and qualified to provide continuous quality care to Molina Members. A Provider may not provide care to Molina Members until the credentialing process is complete and the final decision has been rendered.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicants and for making recommendations regarding their participation in the Molina network. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network Providers, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee Member shall be immune, to the fullest extent provided by Law, from liability to an applicant or Provider for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee Members. Each Member is required to meet all of Molina's credentialing criteria. Credentialing Committee Members must be current representatives of Molina's Provider network. The Credentialing Committee representation includes at least five Providers. These may include Providers from the following specialties:

- Behavioral Health
- Dental

- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc Providers may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Nurses and Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

- Committee Members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by Molina on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements. The Credentialing Committee votes to make final recommendations regarding applicant's participation in the Molina network.
- Conduct ongoing monitoring of those Providers approved to be monitored on a "watch status".
- Access clinical peer input when discussing standards of care for a particular type of Provider when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with Molina's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

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 Member/Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

Molina monitors Provider sanctions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified.

Medicare and Medicaid Sanctions and Exclusions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within thirty (30) calendar days of its release, Molina reviews the report to identify if any Molina Provider is found with a sanction. If a Molina Provider is found to be sanctioned by the OIG the Provider's contract will immediately be terminated effective the same date the sanction was implemented.

Molina also monitors each State Medicaid sanctions/exclusions/terminations through each State's specific Program Integrity Unit (or equivalent). Molina reviews each State's published report within thirty (30) days of its release to identify if any Molina Provider is found to be sanctioned/excluded/terminated from any State's Medicaid program,. If a Molina Provider is found to be sanctioned/excluded/terminated, the Provider will be immediately terminated in every State where they are contracted with Molina and for every line of business.

Sanctions or Limitations on Licensure

Molina monitors for sanctions or limitations against licensure between credentialing cycles for all network Providers. All sanction or limitation of license information discovered during the ongoing monitoring process will be maintained in the Provider credentialing file. All Providers with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a recommendation.

NPDB Continuous Query

Molina enrolls all network Providers with the National Practitioner Data Bank ("NPDB") Continuous Query service.

Once the Provider is enrolled in the Continuous Query Service, Molina will receive instant notification of all new NPDB reports against the enrolled Providers. When a new report is received between recredentialing cycles, the Provider will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

Member Complaints/Grievances

Each Molina Health Plan has a process in place to investigate Provider-specific complaints from Members upon their receipt. Molina evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six (6) months.

Adverse Events

Each Molina Health Plan has a process in place for monitoring Provider adverse events at least every six (6) months. An adverse event is an injury that occurs while a Member is receiving health care services from a Provider. Molina monitors for adverse events at least every six (6) months.

Medicare Opt-Out

Providers participating in Medicare must not be listed on the Medicare Opt-Out report. Molina reviews the Opt-Out reports released from the appropriate Medicare financial intermediary showing all of the providers who have chosen to Opt-Out of Medicare. These reports are reviewed within thirty (30) calendar days of their release. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years. These Provider contracts will be immediately terminated for the Molina Medicare line of business.

Social Security Administration (SSA) Death Master File

Molina screens Provider names against the SSA Death Master File database during initial and recredentialing to ensure Provider are not fraudulently billing under a deceased person's social security number. The names are also screened on a monthly basis to ensure there are no matches on the SSA Death Master File between credentialing cycles. If Molina identifies an exact match, the Provider will be immediately terminated for all lines of business effective the deceased date listed on the SSA Death Master File database.

System for Award Management (SAM)

Molina monitors the SAM once per month to ensure Providers have not been sanctioned. If a Molina Provider is found with a sanction, the Provider's contract is immediately terminated effective the same date the sanction was implemented.

Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care health plans are required to collect specific information from network Providers prior to contracting and during credentialing to ensure that it complies with Federal regulations that require monitoring of Federal and State sanctions and exclusions databases. This monitoring ensures that any network Providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b). The categorical details required and collected are as follows:

1. Molina requires a current and complete Disclosure of Ownership and Control Interest Form during the credentialing process. Molina screens all individual names and entities listed on the form against the OIG, SAM, Medicare Opt-Out and each State's specific Program Integrity Unit databases at the time of initial credentialing and recredentialing. These individual names and entities are also screened monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity This monitoring ensures that any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against Federal and State agency sources, ensuring compliance with 42 CFR §455. The following categorical details are collected and required on the Disclosure of Ownership and Control Interest during the credentialing and recredentialing process:

    a. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).

b. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).
c. Detailed identifying information for all individuals or entities that have a five percent (5%) or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

2. Molina requires the Disclosure of Ownership and Control Interest Form be reviewed and re-attested to every thirty-six (36) months to ensure the information is correct and current.

3. Molina screens the entire contracted Provider network against the OIG, SAM, Medicare Opt-Out, each State's specific Program Integrity Unit and Social Security Death Master File databases at initial credentialing and recredentialing, as well as, monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity.

4. Molina will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers. Molina will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

5. If a State specific Program Integrity Unit notifies Molina an individual or entity is excluded from participation in Medicaid, Molina will terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately.

Office Site and Medical Record Keeping Practices Review

A review of office sites where you see Molina Members may be required. This review may be scheduled as soon as the Credentialing Department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.
Office site and medical record keeping reviews may also be initiated if any Member complaints are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

Range of Actions, Notification to Authorities and Provider Appeal Rights

Molina uses established criteria in the review of Providers' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Range of Actions Available

The Molina Credentialing Committee can take one of the following actions against Providers who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation

- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all Providers who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. If at any point a Provider fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the Provider may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a Provider from the Molina network include, but are not limited to, the following:

1. The Provider's professional license in any State has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct.
3. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any State or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the Provider to Molina Members.
4. Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their Federal Drug Enforcement Agency (DEA) certificate or Registration.
5. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the Provider's practice.
6. Provider has or has ever had sanctions of any nature taken by any Governmental Program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency.
7. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges or surrendered privileges while under investigation by any health care institution, plan, facility or clinic.
6. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
7. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.

8. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of Molina Members.
9. Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
10. Provider has or has ever had a pattern of Member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Members.
11. Provider has not complied with Molina's quality assurance program.
12. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
13. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
14. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
15. Provider has ever rendered services outside the scope of their license.
16. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
17. Provider has or has ever failed to comply with the Molina Medical Record Review Guidelines.
18. Provider has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring Providers Approved on a 'Watch Status' by the Committee

Molina uses the credentialing category "watch status" for Providers whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a Provider to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the Provider needs to be monitored for any reason.
When a Provider is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the Molina Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and recommendation.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the Provider to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.
A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six (6) months)

- Within ten (10) calendar days of the Credentialing Committee's decision to place Provider on a corrective action plan, the Provider will be notified via a certified letter from the Medical Director. Such notification will outline:
- The reason for the corrective action
- The corrective action plan

If the corrective actions are resolved, the Provider's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the Provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate Provider response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Credentialing Committee or the Medical Director becomes aware of circumstances that pose an immediate risk to patients, the Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case. Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the Provider of the suspension by written notification sent via certified letter. Notification will include the following:

- A description of the action being taken.
- Effective date of the action.
- The reason(s) for the action and/or information being investigated.
- Information (if any) required from the Provider.
- The length of the suspension.
- The estimated timeline for determining whether or not to reinstate or terminate the Provider.
- Details regarding the Providers right to request a fair hearing within thirty (30) calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy).
- If the Provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing.
- The action will be reported to the NPDB if the suspension is in place longer than thirty (30) calendar days.

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the Provider's continued participation, discontinue the suspension or terminate the Provider.

Denial

After review of appropriate information, the Credentialing Committee may determine that the Provider should not be approved for participation in the Molina network. The Credentialing Committee may then vote to deny the Provider.

The Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

Termination

After review of appropriate information, the Credentialing Committee may determine that the Provider does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the Provider.

Terminations for Reasons Other Than Unprofessional Conduct or Quality of Care

If the termination is based on reasons other than unprofessional conduct or quality of care, the Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

1. A Description of the action being taken
2. Reason for termination

Terminations Based on Unprofessional Conduct or Quality of Care

If the termination is based on unprofessional conduct or quality of care, the Provider will be given the right to a fair hearing.
Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of Molina's intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

- A Description of the action being taken.
- Reason for termination.
- Details regarding the Provider's right to request a fair hearing within thirty (30) calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina will appoint a hearing officer and a panel of individuals to review the appeal.
- The Provider does not request a fair hearing within the thirty (30) calendar days; they have waived their rights to a hearing.
- The notice will include a copy of the Fair Hearing Plan Policy describing the process in detail.
- Provider's right to be represented by an attorney or another person of their choice.
- Obligations of the Provider regarding further care of Molina Patients/Members.
- The action will be reported to the NPDB and the State Licensing Board.

Molina will wait thirty (30) calendar days from the date the terminated Provider received the notice of termination. If the Provider requests a fair hearing within that required timeframe, Molina will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the Provider will receive written notification of the appeal decision which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee's decision is to uphold the termination, the action will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the Provider remains in the Molina network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the Provider does not request a hearing within the thirty (30) calendar days, they have waived their rights to a hearing and the termination will become the final decision. A written notification of the final termination will be sent to the Provider and the termination will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below.

Reporting to Appropriate Authorities

Molina will make reports to appropriate authorities as specified in the Molina Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Provider based upon Unprofessional Conduct or quality of care. Adverse Actions include:

- Revocation, termination of, or expulsion from Molina Provider status.
- Summary Suspension in effect or imposed for more than thirty (30) calendar days.
- Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

Within fifteen (15) calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate State licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate State licensing boards describing the adverse action taken, the Provider it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate State licensing boards within twenty-four (24) hours of receiving the final NPDB report. A copy of this letter is filed into the Provider's credentials file. The action is also reported to other applicable State entities as required.

Fair Hearing Plan Policy

Under State and Federal Law, certain procedural rights shall be granted to a Provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board and the National Practitioner Data Bank (NPDB).

Molina Healthcare, Inc., and its Affiliates ("Molina"), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina will result in a report to the State Licensing Board and the NPDB.

B. Definitions

1. Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (l)-(3) below.
2. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina Affiliate State plan wherein the Provider is contracted.
3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
4. Medical Director shall mean the Medical Director for the respective Molina Affiliate State plan wherein the Provider is contracted.
5. Molina Plan shall mean the respective Molina Affiliate State plan wherein the Provider is contracted.
6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
7. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
8. Plan President shall mean the Plan President for the respective Molina Affiliate State plan wherein the Provider is contracted.

9. Provider shall mean physicians, dentists, and other health care Practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).
10. State shall mean the licensing board in the State in which the Provider practices.
11. State Licensing Board shall mean the State agency responsible for the licensure of Provider.
12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina Plan.

C. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board and the NPDB.
2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina Members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board and the NPDB.
3. Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

D. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the Provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;
2. State any Credentialing Policy provisions that have been violated;
3. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
4. Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;
5. Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
6. Advise the Provider that the request for a hearing ***must*** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;
7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal Law; and,
8. Provide a summary of the Provider's hearing rights or attach a copy of this Policy.

E. Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the Provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely

written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the Provider with a Notice of Hearing and Statement of Charges consistent with this Policy.
A Provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the Provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the Provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

F. Appointment of a Hearing Committee

Composition of Hearing Committee

The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject Provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a Member of the panel.

The panel shall consist of three or more Providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected Provider. In the event Providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

1. Scope of Authority

   The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

2. Responsibilities

   The Hearing Committee shall:
   a. Evaluate evidence and testimony presented.
   b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
   c. Maintain the privacy of the hearing unless the Law provides to the contrary.

3. Vacancies

   In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

4. Disclosure and Challenge Procedures- Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/Plan President any circumstance likely to affect

impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

G. Hearing Officer

1. Selection

The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

a. Exclude any witness, other than a party or other essential person.
b. Determine the attendance of any person other than the parties and their counsel and representatives.
c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:

a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
b. Ensure that proper decorum is maintained;
c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
d. Issue rulings pertaining to matters of Law, procedure and the admissibility of evidence;
e. Issue rulings on any objections or evidentiary matters;
f. Discretion to limit the amount of time;
g. Assure that each witness is sworn in by the court reporter;
h. May ask questions of the witnesses (but must remain neutral/impartial);
i. May meet in private with the panel members to discuss the conduct of the hearing;
j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and,
l. Prepare the written report.

H. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give notice to the affected Provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes,

the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

I. Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:

1. The date, time and location of the hearing.
2. The name of the Hearing Officer.
3. The names of the Hearing Committee Members.
4. A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

J. Pre-Hearing Procedures

1. The Provider shall have the following pre-hearing rights:
    a. To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and,
    b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.
2. The Hearing Committee shall have the following pre-hearing right:

    To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:

a. Whether the information sought may be introduced to support or defend the charges;
b. The exculpatory or inculpatory nature of the information sought, if any;
c. The burden attendant upon the party in possession of the information sought if access is granted; and,
d. Any previous requests for access to information submitted or resisted by the parties.

4. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.
5. It shall be the duty of the Provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.
7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.
8. Conduct of Hearing
9. Rights of the Parties

   Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:
   a. Call and examine witnesses for relevant testimony.
   b. Introduce relevant exhibits or other documents.
   c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
   d. Otherwise rebut evidence.
   e. Have a record made of the proceedings.
   f. Submit a written statement at the close of the hearing.
   g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

10. The Provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.
11. Course of the Hearing

    a. Each party may make an oral opening statement.
    b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
    c. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.

d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.

e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

12. Use of Exhibits

a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.

b. A description of the exhibits in the order received shall be made a part of the record.

13. Witnesses

a. Witnesses for each party shall submit to questions or other examination.

b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.

c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.

d. The party producing such witnesses shall pay the expenses of their witnesses.

14. Rules for Hearing:

a. Attendance at Hearings
Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee
There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter
Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
    a. The panel members' names and specialties;
    b. The Hearing officer's name;
    c. The date of the hearing;
    d. The charges at issue; and,
    e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.
5. Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the Provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

- The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the Provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at Law, or other representative at the hearing, at their own expense, to represent their interests, present their case, and offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

P. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected Provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

S. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board and the NPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

Reports to the State Licensing Board and the NPDB for adverse actions must be submitted within fifteen (15) days from the date the adverse action was taken.

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the Provider must exhaust the remedies afforded by this Policy before resorting to legal action.

U. Confidentiality and Immunity

Information regarding any Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a Provider's professional qualifications, clinical ability, judgment, character, physical or mental health,

emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or Provider's provision of patient care services.

By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the Provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina membership and the continuation of such membership, and to the exercise of clinical privileges or provision of Patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider;
2. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and Claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina operations and actions relating to Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.
Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant State and Federal Law, and are not a limitation thereof.

Section 6. Delegation

This section contains information specific to medical groups, Independent Practice Associations (IPA), and Vendors contracted with Molina to provide medical care or services to Members, and outlines Molina's delegation criteria and capitation reimbursement models. Molina will delegate certain administrative responsibilities to the contracted medical groups, IPAs, or vendors, upon meeting all of Molina's delegation criteria. Provider capitation reimbursement models range from fee-for-service to full risk capitation.

Delegation of Administrative Functions

Administrative services which may be delegated to IPAs, Medical Groups, Vendors, or other organizations include:

- Call Center
- Care Management
- Claims Administration
- Credentialing
- Non-Emergent Medical Transportation (NEMT)
- Utilization Management (UM)

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions. Call Center, Claims Administration, Care Management and/or Utilization Management functions are generally only delegated to Vendors or full risk entities. Non-Emergent Medical Transportation (NEMT) may be delegated to Vendors who can meet Call Center, Claims Administration and/or NEMT requirements.

Note: The Molina Member's ID card will identify which group the Member is assigned. If Claims Administration and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations.

Delegation Criteria

Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted IPAs, Medical Groups, or Vendors. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

Call Center

To be delegated for Call Center functions, Vendors must:

- Have a Vendor contract with Molina (Molina does not delegate call center functions to IPAs or Provider Groups).
- Have a Call Center delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within the timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste and Abuse.

- Must have an automated call system that allows the Vendor to confirm Member benefits and eligibility during the call.
- Agree to Molina's contract terms and conditions for Call Center delegates.
- Submit timely and complete Call Center delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Current call center is able to demonstrate compliance with service level performance, average speed to answer, abandonment rate, and/or percentage of calls that are complaints meet CMS and/or state requirements, depending on the line(s) of business delegated.

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

Care Management

To be delegated for Care Management functions, Medical Groups, IPAs and/or Vendors must:

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Pass a care management pre assessment audit, based on NCQA and State requirements, and Molina business needs.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for care management delegates.
- Submit timely and complete Care Management delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable federal and state Laws.

Note: Molina does not allow care management delegates to further sub-delegate care management activities.

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

Claims Administration

To be delegated for Claims Administration, Medical Groups, IPAs, and/or Vendors must do the following:

- Have a capitation contract with Molina and be in compliance with the financial reserves requirements of the contract.

- Be delegated for UM by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
- Correct deficiencies within timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
- Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
- Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for Claims Delegates.
- Submit timely and complete Claims Administration delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Within (45) days of the end of the month in which care was rendered, provide Molina with the Encounter Data required by the state in a format compliant with HIPAA requirements.
- Provide additional information as necessary to load Encounter Data within (30) days of Molina's request.
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
- Comply with all applicable Federal and State Laws.
- When using Molina's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina's Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

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

Credentialing

To be delegated for credentialing functions, Medical Groups, IPAs, and/or Vendors 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, SAM, and all published state Medicaid exclusion lists a minimum of every thirty days.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every 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 Medical Group, IPA, or Vendor is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.
If the Medical Group, IPA, or Vendor sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

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

Non-Emergent Medical Transportation (NEMT)

To be delegated for NEMT functions, Vendors must do the following:

- Have a Vendor contract with Molina (Molina does not delegate NEMT functions to IPAs or Medical Groups).
- Pass Molina's NEMT pre-assessment, which is based on State and Federal NEMT requirements.
- Have automated systems that allow for scheduling of NEMT appointments, confirmation of Member eligibility, and availability of NEMT benefits.
- Have processes in place to ensure protection of Member PHI.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a network of vehicles and drivers that meet State and Federal safety requirements.
- Ensure on at least an annual basis that vehicles continue to meet State and Federal vehicle safety requirements.
- Ensure that drivers continually meet State and Federal safety requirements.
- Have a process in place for reporting of all accidents, regardless of harm to Member, to Molina within forty-eight (48) hours.
- Agree to Molina's contract terms and conditions for NEMT delegates, including applicable Call Center and/or Claims Administration delegation requirements.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.

- Submit timely and complete NEMT delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.

Note: If the NEMT Vendor delegates to other sub-contractors, the NEMT Vendor must have a process to ensure that their sub-contractors meet all Health Plan and State and Federal requirements identified above. Evaluation should be done prior to execution of a contract, and annually thereafter. Evaluation should include review of compliance with driver requirements, vehicle requirements, Health Plan, State and Federal requirements, and a process to implement corrective action if issues of non-compliance are identified.

A Vendor may request NEMT delegation from Molina through Molina's Delegation Manager or through the Vendor's Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review. Final decision to delegate NEMT is based on the Vendor's ability to meet Molina's standards and criteria for delegation

Utilization Management (UM)

To be delegated for UM functions, Medical Groups, IPAs, and/or Vendors must:

- Have a UM program that has been operational at least one year prior to delegation, and includes an annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina's UM pre-assessment, which is based on NCQA, State and Federal UM standards, and Molina Policies and Procedures.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Ensure that only licensed physicians/dentists medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Agree to Molina's contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.
- Comply with all applicable federal and state Laws.

Note: If the Medical Group, IPA, or Vendor is an NCQA Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable State requirements and Molina Business needs.
Molina does not allow UM delegates to further sub-delegate UM activities.

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

Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider organizations. Molina will include all network Providers, including those in Medical Groups, IPAs, or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA, or Vendor's Quality Improvement Program.

Delegation Reporting Requirements

Medical Groups, IPAs, or Vendors contracted with Molina and delegated for various administrative functions 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 Provider Services Contract Manager.

Section 7. 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 and Members who are deaf, hard of hearing or have speech or cognitive/intellectual impairments. 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 MolinaHealthcare.com, from your local Provider Services Representative and by calling Molina Provider Services at 855- 326-5059.

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 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 or sex. 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 from a State Medicaid Program.

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

Molina Institute for Cultural Competency

Molina is committed to reducing healthcare disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina founded the Molina Institute for Cultural Competency, which 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 training modules.
Training modules, delivered through a variety of methods, include:

1. Written materials;
2. On-site cultural competency training delivered by Provider Services Representatives;
3. Access to enduring reference materials available through Health Plan representatives and the Molina website; 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 interpreting, American Sign Language (ASL), written translation and access to programs, and aids and services that are congruent with cultural norms. Molina supports Members with disabilities, and assists Members with Limited English Proficiency.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction. Online materials found on MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including Appeals and Grievance forms, are also available in threshold languages on the Molina Member website.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations with plan's membership
    - Revalidate data at least annually
    - Contracted Providers to assess gaps in network demographics
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources
- Network Assessment
- Collection of data and reporting for the Diversity of Membership HEDIS measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.

- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS and CAHPS results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2010

Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services

Molina provides oral interpreting of written information to any plan Member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina notifies plan Members of the availability of oral interpreting services upon enrollment, and informs them how to access oral interpreting services at no cost to them on all significant Member materials. Molina serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for supporting access to interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency.

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 888- 999-2404. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a language service provider. Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. 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 with Hearing Impairment

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), 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 with hearing impairment. Requests should be made three 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 Healthcare's Nurse Advice Line directly (English line 888- 275-8750) or (Spanish line at 866-648-3537) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Section 8. Disease Management

Program Overview

Molina Healthcare of Wisconsin, Inc. wants providers to be aware of disease management programs offered to assist with care management. Molina Healthcare has programs that can help providers manage their patient's condition. Molina Healthcare works closely with Participating Providers in the identification, assessment and implementation of appropriate interventions for Members, including Member health education and providing educational materials. Molina Healthcare's care managers have immediate, reliable access to evidence- based clinical guidelines to conduct assessment and manage Members who are receiving program services. These evidence-based tools include standardized assessments and Member individualized care plans that are available within the secure care management electronic platform.

Disease-specific interventions include but are not limited to:

- Asthma
- Diabetes
- Hypertension
- Coronary Artery Disease Congestive Heart Failure COPD

A care manager/nurse is on hand to teach Members about their disease. He/she will manage the care with the Member's assigned PCP and provide other resources. There are many ways a Member can enroll in these programs. One way is through medical or pharmacy Claims. Another way is through doctor Referral. Members can also ask Molina Healthcare to enroll them. It is the Member's choice to be in these programs. A Member can choose to dis-enroll from the program at any time.

For more info about Molina Healthcare's programs, please call Member Services Department at 888-999-2404.

Breathe with Ease

Molina Healthcare of Wisconsin, Inc. provides an Asthma Disease Management program called Breathe with Ease, designed to assist Members in understanding their asthma condition. Molina Healthcare has a special interest in asthma, as it is one of the top chronic diagnoses for its Members. This program is based on NHLBI Asthma Guidelines and meets NCQA requirements. The program educates the Member and family about asthma symptom identification and control. Molina Healthcare's goal is to partner with the provider to strengthen asthma care in the community.

Breathe with Ease Program Activities

Members are managed based on individual needs which also determine the frequency of contact. Low risk Members are provided with general asthma education and an asthma newsletter. Molina Healthcare's goal is to provide Members with a basic understanding of asthma and related concepts, such as common triggers. Molina Healthcare also encourages Members to see their PCP regularly for asthma status checks, and important preventive and well-childcare.

Molina also offers Members identified as having high needs an opportunity to participate in a more intensive asthma program. These Members are contacted more frequently and assisted with

understanding on how to use their medications, making provider appointments or ensuring that they receive specialty care.

Additional Asthma Program Benefits

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with asthma. A Registered Nurse (RN) Care Manager calls all patients hospitalized for complications related to asthma. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent to the PCP's office upon request.
- Condition-targeted education materials.
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members.

Healthy Living with Diabetes

Molina Healthcare has a diabetes health management program called Healthy Living with Diabetes designed to assist Members in understanding diabetes and self-care. Molina Healthcare's diabetes health management program follows the standards and guidelines established by NCQA.

The goals of diabetes management are to:

- Complete a diabetes self-management program and initiate a personal action plan. Maintain (near) normal AI-c or meet established AI-c goal.
- Obtain annual preventive exams and tests (AI-c, dilated retinal exam, urine micro albuminuria, foot exam, and lipid panel).
- Adhere to optimal medication regimen and avoid adverse effects from diabetes medications.
- Initiate and maintain a regular program of brisk walking or other preferred physical activity.
- Prevent acute episodes of diabetes necessitating emergency room visits or hospitalizations.
- Identify psychosocial issues (access to treatment, cultural & religious beliefs or positive depression screenings) and modify interventions to support adherence.
- Meet Members' and families' expectations and satisfaction with diabetes care.
- Support Participating Provider network in improving the quality of care with persons who have diabetes.

The Healthy Living with Diabetes program includes:

1. Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with diabetes. An RN Care Manager calls all patients hospitalized for complications related to diabetes. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent to the PCP's office upon request.
2. Clinical Practice Guidelines – Molina Healthcare adopted the American Diabetes Association (ADA) guidelines for diabetic care.
3. Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members.
4. Diabetes Education – Member education and materials are provided to all participants. We encourage providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.

Heart Healthy Living – Cardiovascular Disease (CVD) Management Program

Molina Healthcare's *Heart Healthy Living* disease management program is a collaborative team approach comprised of patient education, clinical case management and provider education. The team works closely with Participating Providers in the identification, assessment and implementation of appropriate interventions for Members with CVD.

While CVD can encompass many different conditions that often co-exist, Molina Healthcare has chosen to target three (3) subprograms: heart failure, coronary artery disease (CAD) and hypertension. The literature supports the selection of these three (3) conditions as being responsive to interventions aimed at the development of adequate self-management skills in optimizing clinical outcomes and improving quality of life.

The Heart Healthy Living program includes:

1. Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with CVD. An RN Care Manager calls all patients hospitalized for complications related to CVD. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent to the PCP's office upon request.
2. Clinical Practice Guidelines – Molina Healthcare adopted the National Heart, Lung and Blood Institute (NHLBI) and the American Heart Association guidelines for cardiovascular care.
3. Cardiovascular Disease Newsletters – Molina Healthcare distributes newsletters to CVD Members.
4. Cardiovascular Disease Education – Member education and materials are provided to all participants. Molina Healthcare encourages providers to refer patients to these services, especially for newly diagnosed heart disease or those having difficulty managing their disease.

Healthy Living with COPD

Molina Healthcare's *Healthy Living With COPD* health management program is a collaborative team approach comprised of patient education, clinical case management and provider feedback. Molina Healthcare works closely with Participating Providers in the identification, assessment and implementation of appropriate interventions for Members with COPD. The goal is to provide a continuum of coordinated, comprehensive care that reduces acute episodes requiring Emergency Care, and promotes improved quality of care for Members.

The Healthy Living with COPO program includes:

1. Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with COPD. An RN Care Manager calls all patients hospitalized for complications related to COPD. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment can be sent the PCP's office upon request.
2. Clinical Practice Guidelines – Molina Healthcare follows the Global Initiative for Chronic
3. Obstructive Lung Disease (GOLD) guidelines for COPD care.
4. COPD Newsletters – Molina Healthcare distributes newsletters to COPD Members.
5. COPD Education – Member education and materials are provided to all participants. Molina Healthcare encourages providers to refer patients to these services, especially for newly diagnosed Members or those having difficulty managing their disease.

Pregnancy Health Management Program

Molina Healthcare cares about the health of its pregnant Members and their babies. Molina Healthcare's pregnancy health management programs are designed to make sure the Member and her baby gets the needed care during the pregnancy. Case Managers are available to assist in the management of high-risk pregnant Members during the pregnancy, in the post- partum period and between pregnancies. Molina Healthcare requests that providers complete and return the pregnancy notification form as soon as pregnancy is confirmed. In addition to providing Members access to a highly care-focused program, Molina Healthcare offers incentives for each notification of pregnancy (NOP) form that providers submit prior to the 3rd Trimester.

Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate-to-high-risk for a disease condition for the mother, the baby or both. "Healthy Baby and Me" is an OB Medical Home program available to Members who are identified as having a high risk pregnancy and meet the program requirements. This comprehensive prenatal program includes the services of a Care Coordinator embedded in the OB provider's office. Contact Molina Healthcare at 855-326-5059 for more information or to make a referral to this program.

The Motherhood Matters℠ pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester-specific assessment and interventions appropriate to the potential risks and needs identified. The Motherhood Matters℠ program does not replace or interfere with the Member's physician assessment and care. The program supports and assists physicians in the delivery of care to Members.

The Motherhood Matters℠ pregnancy management program encompasses clinical case management, disease management and Member education, 24-hour Nurse Advice Line, Member outreach and provider communication. The prenatal case management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every Member participating in the program. The program activities include early identification of pregnant Members, early screening for potential risk factors, provision of telephonic and written trimester-appropriate education to all pregnant Members, referral of high-risk Members to prenatal case management, and provision of assessment information to physicians.

Prenatal Case Management – Members assessed to be high risk are contacted via telephone for further intervention and education. A care plan is developed and can be shared with the physician to ensure that all educational and care needs are met. Prenatal case management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care Referrals, coordination of home health care and DME service and referral to support groups or community social services. The case management database generates reminders for callbacks for specific assessments, prenatal visits, and postpartum visits.

Member Outreach – The Motherhood Matters℠ Program is promoted to Members through various means including, the Member Handbook, Member mailings, provider newsletters, and marketing materials.

Program Eligibility Criteria and Referral Source

Program interventions are designed for Molina Healthcare Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the Molina Healthcare's coverage or until the Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with his/her health condition(s). Additionally, all identified Members will receive regular educational newsletters. The program model provides an "opt-out" option for Members who contact Molina Healthcare and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following: Pharmacy data for all classifications of medications;

- Encounter Data or paid Claim with a relevant diagnosis code
- Member Services welcome calls made by staff to new Member households and incoming Member calls. Eligible Members are referred to the program; Practitioner/provider 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.

Practitioner/Provider Participation

Participating Providers may be notified whenever their patients are enrolled in a disease management program.

Practitioner/provider resources and services may include:

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

To find out more information about the disease management programs, please call Molina Healthcare at 855-326-5059.

Section 9. Enrollment, Eligibility and Disenrollment

Identification Cards

Molina Healthcare Members are issued one membership card, identified as a ForwardHealth card. The card is not dated, nor is it returned when a Member becomes ineligible. Therefore, the presence of a card does not ensure that a person is currently enrolled or eligible with Molina Healthcare.

A ForwardHealth card contains the following information:

- Member's name
- Medicaid identification number

Possession of a Member identification card does not guarantee that the Member is eligible for benefits. Providers are strongly encouraged to check Member eligibility frequently. Member eligibility changes occur frequently. To facilitate reimbursement for services, providers are strongly advised to verify a Member's eligibility upon admission to treatment and on each subsequent date of service.

Enrollment

Enrollment in Medicaid Programs

The Wisconsin Department of Health Services (DHS) implements Title XIX of the Social Security Act (Medicaid). DHS, through its Forward Health program takes applications and determines the eligibility of individuals and families for BadgerCare Plus and Medicaid SSI. Only individuals who are included in the eligible populations and living in counties with authorized health plans are eligible to enroll and receive services from Molina Healthcare. Molina Healthcare of Wisconsin, Inc. Participates in BadgerCare Plus and Medicaid SSI coverage programs.

To enroll with Molina Healthcare, an applicant, his/her representative, or his/her responsible parent or guardian must complete and submit an application through his/her county agency or through the DHS website called ACCESS. BadgerCare Plus or SSI can be applied for through any of the following:

- online at: www.access.wisconsin.gov
- Telephone by calling Enrollment Services Center at I-800-29I-2002
- In person or by mail at his/her local county or tribal agency.
    - Applicants can find the county location, by calling I-800-29I-2002 or by going to dhs.wisconsin.gov/em/customerhelp

DHS will enroll all eligible applicants into the health plan of their choice. If the applicant does not choose a plan, DHS will assign the applicant and his/her family to a plan that services the area where the applicant resides.

Providers are allowed to educate/inform their patients about the BadgerCare Plus and Medicaid SSI HMOs with which they contract.

Providers are allowed to inform their patients of the benefits, services, and specialty care services offered through the BadgerCare Plus or Medicaid SSI HMOs in which they participate.

Providers are allowed to give a patient contact information for a particular BadgerCare Plus or Medicaid SSI HMO, but only at the patient's request.

Providers are allowed to assist potentially eligible individuals with enrollment in the BadgerCare Plus and/or Medicaid SSI programs by helping them:

- Apply online at the Access website: www.access.wisconsin.gov;
- Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf; or
- Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm

Providers are allowed to assist potentially eligible individuals with the BadgerCare Plus express enrollment process, as described on the ForwardHealth Portal at www.forwardhealth.wi.gov, if they qualify.

Providers are allowed to refer patients with questions about the BadgerCare Plus and/or Medicaid SSI programs to an HMO Enrollment Specialist at 1-800-291-2002. HMOs are allowed to conduct orientations, health fairs, or community baby showers for their members in a private setting at a provider's office. D-SNP plans are allowed to have agreements with providers in connection with plan marketing activities as long as the activity is consistent with Medicare regulations. D-SNP plans may use providers/and or facilities to distribute plan marketing materials as long as the provider and/or the facility distributes marketing materials for all plans with which the provider participates.

Providers are prohibited from recommending one HMO over another HMO, offering patients incentives to select one HMO over another HMO, or assisting the patient in deciding to select a specific HMO.

Per the Medicare Marketing Guidelines, providers participating in D-SNP plans must remain neutral when assisting members with enrollment decisions to ensure that providers do not appear to be a D-SNP plan agent.

No eligible applicant 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.

Newborn Enrollment

PCPs are required to notify Molina Healthcare via the Pregnancy Notification form immediately after the first prenatal visit and/or positive pregnancy test of any Member presenting herself for health care services. The Pregnancy Notification form can be accessed on Molina Healthcare's website using the following link: http://www.MolinaHealthcare.com/providers/wi/medicaid/forms/PDF/pregnancy-notification-form.pdf

Eligibility Verification

Medicaid Programs

The State of Wisconsin, through the DHS, determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and Molina Healthcare places the responsibility for eligibility verification on the provider of services.

Eligibility Listing for Medicaid Programs

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

- Molina Healthcare Provider Web Portal
- Molina Healthcare of Wisconsin, Inc. at 855-326-5059
- Molina Healthcare of Wisconsin, Inc. Interactive Voice Response System (IVR) at 888-999-2404

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.

ForwardHealth Medical Cards

Members are reminded in their Member Handbooks to carry their ForwardHealth Medical ID cards with them when requesting medical services. It is the provider's responsibility to ensure Molina Healthcare Members are eligible for benefits and to verify PCP assignment, prior to rendering services.

PCP Assignments

Molina Healthcare will offer each Member a choice of PCPs. After making a choice, each Member will have a single PCP. Molina Healthcare will assign a PCP to those Members who did not choose a PCP at the time of enrollment with Molina Healthcare. Molina Healthcare will take into consideration the Member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the Member's home address, ZIP code location, keeping children/adolescents within the same family together, age (adults versus children/adolescents) and gender (OB/GYN). Molina Healthcare will assign all Members that are reinstated after a temporary loss of eligibility of 60 days or less to the PCP who was treating them prior to loss of eligibility, unless the Member specifically requests another PCP, the PCP no longer participates in Molina Healthcare or is at capacity, or the Member has changed geographic areas.

PCP Changes

A Member may change his/her PCP at any time by contacting Molina Healthcare's Member Services Department at 888-999-2404.

Section 10. Fraud, Waste, and Abuse

Introduction
Molina Healthcare of Wisconsin maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with Federal and State statutes and regulations. Molina Healthcare of Wisconsin is dedicated to the detection, prevention, investigation, and reporting of potential health care Fraud, Waste, and Abuse. As such, the Compliance Department maintains a comprehensive plan, which addresses how Molina Healthcare of Wisconsin will uphold and follow State and Federal statutes and regulations pertaining to Fraud, Waste, and Abuse. The program also addresses Fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of Wisconsin

Mission Statement
Molina Healthcare of Wisconsin regards health care Fraud, Waste and Abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina Healthcare of Wisconsin has, therefore, implemented a program to prevent, investigate, and report suspected health care Fraud, Waste and Abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers Fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. 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
On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into law, which became effective on January 1, 2007. The DRA aims to cut Fraud, Waste and Abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Wisconsin who receive or pay out at least $5 million in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare of Wisconsin, 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 a whistleblowers.

The Federal False Claims Act and the 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 Acts. 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 Healthcare will take steps to monitor Molina Healthcare of Wisconsin contracted providers to ensure compliance with the law.

Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and State Medicaid sanction reports.
- Federal and State lists of excluded individuals and entities including but not limited to the
- OIG, GSA, SAM, EPLS, LEIE, MED and CMS.
- List of parties excluded from Federal Procurement and Non-procurement Programs. Medicaid suspended and ineligible provider list.
- Monthly review of State Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information, the documents are presented to the Credentialing Committee for review and potential action. The Credentialing Services staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider / Practitioner Education

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

The Molina Healthcare of Wisconsin Provider Services Representative will inform the provider's office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Contracted Molina providers are required to make policies and procedures available upon request, according to the NCQA and state Medicaid contractual requirements.

Review of Provider Claims and Claims System

Molina Healthcare 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 Healthcare of Wisconsin 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.

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered. Providing services to patients that are not Medically Necessary.
- Balance billing a Medicaid member for Medicaid Covered Services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the Provider’s usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and/ or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment,
- "up-coding", and billing for services not provided.
- Concealing patients' misuse of ForwardHealth identification card. Failure to report a patient's forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which the physician has a financial relationship.

Misuse and Abuse of Benefits

Providers May Refuse to Provide Services
Providers may refuse to provide services to a BadgerCare Plus or Medicaid Member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to other limitations.

Scheduling Appointments
Molina Healthcare would like its PCPs to monitor Member appointment compliance and suggests that providers contact both new and existing Molina Healthcare Members to help schedule appointments. Molina Healthcare believes that providers should contact Members twenty-four (24) hours prior to an appointment to confirm the appointment to help decrease the number of missed appointments.

Missed Appointments
The provider will document and follow up on appointments missed and/or canceled by the Member. Providers should notify Molina Healthcare when a Member misses two consecutive appointments.

Reporting Fraud, Waste and Abuse

If you suspect cases of Fraud, Waste, or Abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global,

a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare 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 Healthcare 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 Healthcare of Wisconsin's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Wisconsin
Attn: Compliance
PO Box 242480
Milwaukee, WI 53224

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
- Address,
- Phone number,
- ForwardHealth ID number or Provider NPI identification and
- Any other identifying information.

Suspected Fraud and Abuse may also be reported directly to the Wisconsin Department of Health Services or United States Office of Inspector General at:

Department of Health Services Public Assistance Fraud Unit Attention:
Fraud Prevention Investigation
P.O. Box 309 Madison, W I 53701-3432
Toll-free phone: (877) 865-3432
Toll-free hotline of the Office of Inspector General: (800) 447-8477

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

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

Provider Responsibilities
Molina Healthcare expects that its contracted Provider will respect the privacy of Molina Healthcare 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.

Applicable Laws
Providers must understand all State and Federal healthcare 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 healthcare Providers are subject to various Laws and regulations pertaining to privacy of health information, which may include, but are not limited to, the following:

- Federal Laws and Regulations
- HIPAA
- The Health Information Technology for Economic and Clinical Health Act (HITECH) Medicare and Medicaid Laws
- The Affordable Care Act
- Applicable State Laws and Regulations

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

Uses and Disclosures of PHI
Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and healthcare 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. Disclosure of PHI by one covered entity to another covered entity, or healthcare Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare 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. 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 Healthcare for our healthcare operations activities, such as HEDIS and Quality Improvement.

Inadvertent Disclosures of PHI
Molina Healthcare may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Healthcare 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 Healthcare Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI, unless otherwise permitted by Law.

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

Patient Rights
Patients are afforded various rights under HIPAA. Molina Healthcare 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 healthcare 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 healthcare 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 healthcare operations or made prior to April 14, 2003.

HIPAA Security
Providers should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a

rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the healthcare 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 healthcare 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 Healthcare.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Molina Healthcare. Under HIPAA, Molina Healthcare 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.

HIPAA Transactions and Code Sets

Molina Healthcare requires the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers must submit Claims and other transactions to Molina Healthcare 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 Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should visit our website at MolinaHealthcare.com to view additional information regarding HIPAA standard transactions. Providers can navigate to this informative page starting from Molina's website:

1. Select the area titled "For Health Care Professionals"
2. From the top of the web page, click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transaction Readiness."

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.

About ICD-10

ICD-10-CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding
2. ICD-10-PCS for inpatient procedure coding

ICD-10-CM is for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.

ICD-10-PCS is for use in U.S. inpatient hospital settings only. ICD-10 PCS uses 7 alphanumeric digits instead of the 3 or 4 numeric digits used under ICD-9-CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially different from ICD-9-CM procedure coding.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.

Fraud, Waste and Abuse Definitions

Fraud - "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 - 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. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent. However, the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

Abuse - "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)

Section 11. Member Rights & Responsibilities

This section explains the rights and responsibilities of Molina Healthcare Members. Wisconsin law requires that health care providers or health care facilities recognize Member rights while he/she is 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 patients. Below are the Member Rights and Responsibilities.

Molina Healthcare Member Rights & Responsibilities Statement

Members Have the Right to:

- Receive the facts about Molina Healthcare, its services and its contracted providers. Have privacy and be treated with respect and dignity.
- Help make decisions about their health care. They may refuse treatment.
- Request and receive a copy of their Medical Records or request an amendment or correction.
- Openly discuss their treatment options in a way they can understand. It does not matter what the cost or benefit coverage.
- Voice any Complaints or Appeals about Molina Healthcare or the care they were given. Use their Member rights without fear of negative results.
- Receive their Member rights and responsibilities at least yearly. Suggest changes to these Member rights and responsibilities.
- Ask for an interpreter and have one provided to them during any BadgerCare Plus and/or
- Medicaid SSI Covered Service.
- Availability and accessibility of all Covered Services. When medically appropriate, services must be available twenty-four (24) hours a day, seven (7) days a week.
- Be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal. Receive information about their treatment options, including the right to receive a second opinion. An independent review of any final decisions regarding their health care made by Molina Healthcare.
- Receive information in the Member Handbook in another language or another format. Receive health care services as provided for in Federal and State law.
- Make decisions about their health care.

Members have the Responsibility to:

- Give, if possible, all facts that Molina Healthcare and the providers need to care for them. Know their health problems and take part in making agreed upon treatment goals as much as possible
- Follow the care plan instructions for care which they have agreed to with their provider. Keep appointments and be on time. If Members are going to be late or cannot keep an appointment, they should call their provider.

Second Opinions

If a Member does not agree with his/her provider's plan of care, he/she has the right to a second opinion from another provider, subject to Referral procedures approved by DHS. Members should call the Molina Healthcare of Wisconsin, Inc. Member Services Department to find out how to get a second opinion.

Out-of-Network Services
If a Molina Healthcare provider is unable to provide a Member with necessary and Covered Services, Molina Healthcare must cover the needed services through an out-of-network provider. This must be done in a timely manner for as long as Molina Healthcare is unable to provide the service.

Non-Discrimination Policy and Regulations
In signing Molina Healthcare's provider services agreement (PSA), providers agree to treat Members without discrimination. Providers may not refuse to accept and treat a Member on the basis of his/her income, physical or mental condition, age, gender, sexual orientation, religion, creed, color, physical or mental disability, national origin, English proficiency, ancestry, marital status, veteran's status, occupation, Claims experience, duration of coverage, race/ethnicity, pre-existing conditions, health status or ultimate payer for services. In the event that the provider does not have the capability or capacity to provide appropriate services to a Member, the provider should direct the Member to call Molina Healthcare for assistance in locating needed services.

Providers may not close their practice to Members unless it is closed to all patients. The exception to this rule is that a provider may decline to treat a Member for whom he/she does not have the capability or capacity to provide appropriate services. In that case, the provider should have the Member call Molina Healthcare for assistance in locating appropriate services. State and Federal laws prohibit discrimination against any individual who is a member of Federal, State, or local public assistance, including medical assistance or unemployment compensation, solely because the individual is such a member. It is Molina Healthcare's goal to ensure that all Members receive behavioral health care that is accessible, respectful, and maintains the dignity of the Member.

Confidentiality of Members'

Confidentiality of Member Information
All providers are expected to comply with Federal, State and local laws regarding access to Member information. With the enactment of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Members give consent for the release of information regarding treatment, payment and health care operations at the sign-up for health insurance. Treatment, payment and health care operations involve a number of different activities, including, but not limited to:

- Submission and payment of Claims.
- Seeking Authorization for extended treatment.
- Quality improvement initiatives, including information regarding the diagnosis, treatment and condition of Members in order to ensure compliance with contractual obligations.
- Member information reviews in the context of management audits, financial audits or program.
- Evaluations.
- Chart reviews to monitor the provision of clinical services and ensure that Authorization criteria are applied appropriately.

Behavioral Health Member Consent

At every intake and admission to treatment, the provider should explain the purpose and benefits of communication to the Member's PCP and other relevant providers. The behavioral health clinician should then ask the Member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional Member status information.

Molina Healthcare provides a *Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form* that can be found at the following link:

http://www.molinahealthcare.com/providers/wi/medicaid/forms/PDF/provider-pcp-communication-form.pdf

or providers may use their own form, however, the form must allow the Member to limit the scope of information communicated. Members can elect to authorize or refuse to authorize release of any information, except as specified in the previous section, for treatment, payment and operations. Whether consenting or declining, the Member's signature is required and should be included in the Medical Record. If a Member refuses to release information, the provider should clearly document the Member's reason for refusal in the narrative section on the form.

HIV-Related Information

Molina Healthcare works to provide comprehensive health care services to Members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Molina Healthcare coordinates care through medical and disease management programs and accepts Referrals for behavioral health case management. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available; and Molina Healthcare will assist behavioral health providers or Members interested in obtaining any of this information by referring them the Case Management Department. Molina Healthcare limits access to all health-related information, including HIV-related information and Medical Records, to staff trained in confidentiality and the proper management of patient information. Molina Healthcare's case management protocols require Molina Healthcare to provide any Member with assessment and Referral to an appropriate treatment source. It is Molina Healthcare's policy to follow Federal and State information laws and guidelines concerning the confidentiality of HIV-related information.

Section 12. Health Care Services (previously UM) Medical Management Program

Introduction

Molina provides care management services to Medicaid Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated care management 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. Elements of the Molina medical management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. You can contact the Molina UM Department for toll free at (855) 326-5059. The UM Department fax number is (877) 708-2117.

Care Access and Monitoring (Utilization Management)

Molina's Utilization Management (UM) program, referred to as Care Access and Monitoring (CAM) ensures appropriate and effective utilization or services. The UM (CAM) team works closely with the Care Management (CM) 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. To reflect the vital role this process plays in Molina's innovative HCS program, the UM (CAM) program ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the levels of care needed for a Member. This program promotes the provision of quality, cost-effective and medically appropriate services that are offered across a continuum of care, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence Member's care by:

- Identify medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the healthcare services provided
- Continually monitor, evaluate and optimize the use of healthcare resources while evaluating the necessity and efficiency of health care services across the continuum of care;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource
- utilization while monitoring utilization practice patterns of Providers, hospitals and ancillary
- Providers to identify over and under service utilization;
- Identify and assess the need for Care Management/Health Management through early identification of high or low service utilization and high cost, chronic or long term diseases; Promote health care in accordance with local, state and national standards;
- Identify events and patterns of care in which outcomes may be improved through efficiencies in
- UM, and to implement actions that improve performance by ensuring care is safe and accessible Ensuring that qualified health care professionals perform all components of the UM / CM processes while ensuring timely responses to Member appeals and grievances
- Continually seek to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decision.

- Coordinate services between the Members Medicare and Medicaid benefits when applicable.
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

The table below outlines the key functions of the Care Access and Monitoring 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 (CAM) program using Member and practitioner input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensuring authorized care correlates to Member's medical necessity need(s) & benefit plan	Retrospective Review	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 (CAM) functions	Monitor for adherence to CMS, NCQA, state and health plan UM (CAM) standards

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to, MCG (formerly known as Milliman Care Guidelines), Interqual, other third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.

Clinical Information

Molina Healthcare 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 Healthcare does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations or the Molina Healthcare Hospital or Provider Services Agreement require 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 updated annually, or more frequently as appropriate, and the current documents are posted on the Molina website.

Requests for prior authorizations to the UM Department may be sent by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number, etc.)
- Clinical information sufficient to document the Medical Necessity of the requested service Provider demographic information (referring Provider and referred to Provider/facility) Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes Location where service will be performed
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions) Pertinent medical history (include treatment, diagnostic tests, examination data) Requested Length of stay (for inpatient requests)
- Indicate if request is for expedited or standard processing

Services performed without authorization will not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements.

Molina will process any non-urgent requests within fourteen (14) calendar days of receipt of request. Urgent requests will be reviewed within seventy-two (72) hours of receipt of 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 a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (855) 326-5059.

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date(s) of service (for Market Place members this includes grace period status), benefit limitations or exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.

Requesting Prior Authorization

Web Portal: Providers are encouraged to use the Molina Healthcare Web Portal for prior Authorization submission. Instructions for how to submit a prior Authorization request are available on the Web Portal.

Fax: The Prior Authorization form can be faxed to Molina at: 877-708-2117. If the request is not on the form provided in this manual, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax if the request is urgent or non-urgent. **The Definition of expedited/urgent is when the situation where the standard time frame or decision making process (up to 14 days per Molina's process) could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function.** Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible.

Phone: Prior Authorizations can be initiated by contacting Molina Healthcare's Healthcare Services Department at 855-326-5059. Providers may need 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 Wisconsin, Inc.
Attn: Healthcare Services Dept.
PO Box 242480
Milwaukee, WI 53224

Prior Authorization Guidelines and Request Form

The Prior Authorization Guidelines can be found at:
http://www.MolinaHealthcare.com/providers/wi/medicaid/forms/pages/fuf.aspx

The Prior Authorization Request Form can be found at:
http://www.MolinaHealthcare.com/providers/wi/medicaid/forms/pages/fuf.aspx

Admissions

Hospitals are required to notify Molina within (24) hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will not be approved.

Elective Inpatient Admissions - Molina Healthcare requires prior Authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior Authorization will not be eligible for payment.

Please note: Facilities are responsible for Admission Notification for inpatient services even if a pre-service coverage approval is on file.

Emergent Inpatient Admissions- Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. 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 (see definition above) sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Concurrent Inpatient Review - Molina Healthcare performs concurrent inpatient review in order to ensure patient safety, 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 Healthcare will request updated original clinical

records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina Healthcare requires that requested clinical information updates be received by Molina Healthcare from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates will result in denial of Authorization for the remainder of the inpatient admission.

Inpatient Status Determinations
Molina's Care Access and Monitoring (CAM) staff determine if the collected medical records and 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. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. 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. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

Concurrent Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The concurrent review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Post Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

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, CMS Medical Coverage Guidelines, Local and National Coverage Determinations, CMS Policy Manuals, regulation and guidance and evidence based criteria sets.

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

Readmission Policy - Hospital Readmissions within thirty-one (31) days potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina Healthcare will review all hospital subsequent admissions that occur within the time frames allowed by Federal and State law of the previous discharge for all Claims. Reimbursement for Readmissions will not be issued for the first discharge unless it meets one (I) of the exceptions noted below, violates State and/or Federal law or violates the terms of the Hospital or Provider Services Agreement between the provider and Molina.

Exceptions:

The Readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate Discharge Planning in the first admission necessitated the second admission; or

The Readmission is part of a Medically Necessary, prior authorized or staged treatment plan; or

There is clear Medical Record documentation that the patient left the hospital against medical advice during the first hospitalization prior to completion of treatment and Discharge Planning.

Medical Necessity Standards

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
- Consistent with the generally accepted professional medical standards as determined by applicable
- Federal and State regulation or law, and not be experimental or investigational;
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the provider.
- The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service.

Specialty Pharmaceuticals/injectable and infusion Services

Please contact the State of Wisconsin for pharmacy prior Authorizations at 800-291-2002 or by fax at (608) 221-8616.

Emergency Care Services

Emergency Care services are covered on a twenty-four (24) hour basis without the need for prior Authorization for all Members experiencing a Medical Emergency.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Care services rendered to the Member do not require prior Authorization from Molina Healthcare.

Members accessing the emergency department inappropriately will be contacted by Molina Healthcare Case Managers whenever possible to determine the reason for using Emergency Care 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.

Molina Healthcare of Wisconsin, Inc. accomplishes this service by providing a twenty-four (24) hour Nurse Triage option on the main telephone line for post-business hours. In addition, the 911 information is given to all Members at the onset of any call to the Molina Healthcare.

For Members within the Service Area: Molina Healthcare of Wisconsin, Inc. contracts with vendors that provide twenty-four (24) hour Emergency Care services for ambulance and hospitals.

Medical Management Definitions

Readmission- A subsequent admission to an acute care hospital within a specified time frame of a prior admission for a related condition or as readmission is defined by State laws or regulations.

Related Condition- A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission

Non- Participating Providers - Molina Healthcare maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive Credentialing process in order to provide medical care for Molina Healthcare Members. Molina Healthcare 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-Participating Provider, all care provided by non-Participating Providers must be prior authorized by Molina Healthcare. Non-Participating 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.

Emergency services for this section is defined as: A) medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Avoiding Conflict of Interest
The Healthcare Services Department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Molina Healthcare does not reward providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage Authorization decision-makers to make determinations that result in under-utilization. Molina Healthcare also requires its delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care
Molina Healthcare's Integrated Care Management, which includes Utilization Management, Case Management and Disease Management, will work with providers to assist with coordinating services and benefits for Members with complex needs and issues. It is the responsibility of Participating Providers to

assess Members, and with the participation of the Member and his/her representative(s), create a treatment care plan. The treatment plan is to be documented in the Medical Record and is updated as conditions and needs change.

Molina Healthcare 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 Healthcare is done in partnership with providers and Members to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members
It is Molina Healthcare's policy to provide Members with advance notice when a provider they are seeing will no longer be a Participating Provider. Members and providers are encouraged to use this time to transition care to a Participating 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 non-Participating Provider for a given period of time. For additional information regarding continuity of care and transition of Members, please contact Molina Healthcare at 855-326-5059.

Continuity and Coordination of Provider Communication
Molina Healthcare 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.

Case Management

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

The Molina Healthcare case managers are licensed professionals and are educated, trained and experienced in the case management process. The CM 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 CM program is individualized to accommodate a Member's needs with collaboration and approval from the Member's PCP. The Molina Healthcare case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and Preventive Care services. The Molina Healthcare case manager is responsible for assessing the Member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, Specialists, 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 case management and should be referred to the Molina Healthcare CM 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 ER services inappropriately
- Children with Special Health Care Needs

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

Phone: 855-326-5059
Fax: 877-708-2117

PCP Responsibilities in Case 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 case management plan. The PCP is responsible for the provision of Preventive Care services and for the primary medical care of Members.

Case Manager Responsibilities

The case manager collaborates with all resources involved and the Member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, providers, and the Member are responsible for implementing the plan of care. Additionally, the case manager:

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

Molina Healthcare's Health Education and Disease Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation and wellness.

Section 13. Provider Responsibilities

Nondiscrimination 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 or sex. 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 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: MolinaHealthcare.AlertLine.com
Email: Civil.Rights@MolinaHealthcare.com

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider Network and Members.
Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA© required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

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

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition or termination of a Provider (within an existing clinic/practice)
- Change in Tax ID and/or 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 Providersearch.MolinaHealthcare.com to validate your information. Please notify your Provider Services Representative or MHWIProvider.Services@MolinaHealthcare.Com if your information needs to be updated or corrected.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Providers are required to provide timely responses to such communications.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

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, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA) and registration for and use of Molina's Provider Web Portal (Provider Portal).

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

Any Provider insisting on paper claims submission and payment via paper check will be ineligible for Contracted Provider status within the Molina network.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by registering for Molina's Provider Web Portal, and submitting electronic claims upon entry into the network. Providers entering the network as a Contracted Provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options

- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Provider Web Portal

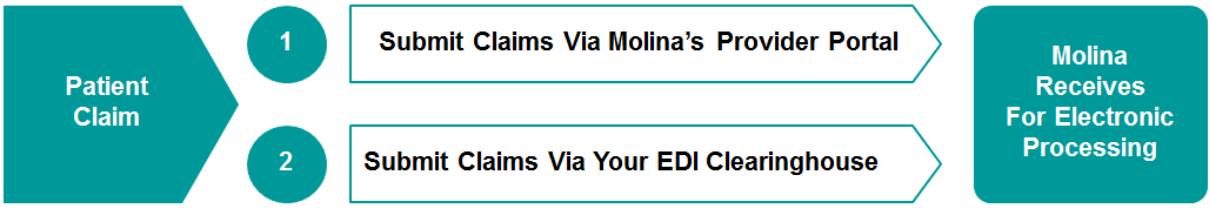
Electronic Claims Submission Requirement

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

- Ensures HIPAA compliance
- Helps to reduce operational 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 Healthcare of Wisconsin via the Provider Portal. See our Provider Web Portal Quick Reference Guide 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 ABRI1, refer to our website MolinaHealthcare.com for additional information.



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

- Ability to 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

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 for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, the ability to have searchable ERAs, and to 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.
Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: 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 Web Portal

Providers are required to register for and utilize Molina's Provider Web Portal (Provider Portal). The 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
- Claims Functions
    - Professional and Institutional Claims (individual or multiple claims)
    - Receive notification of Claims status change
    - Correct Claims
    - Void Claims
    - Add attachments to previously submitted claims
    - Check Claims status
    - Export Claims reports
    - Appeal Claims
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization Requests
    - Check status of Authorization Requests
    - Receive notification of change in status of Authorization Requests
- View HEDIS® Scores and compare to national benchmarks

Balance Billing

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 may not charge Members fees for covered services.

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 comply with the Member Rights and Responsibilities as outlined in Member materials (such as Member Handbooks documents). More information is available in the Member Rights and Responsibilities section in this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Molina prior to use. Please contact your Provider Services Representative for information and review of proposed materials.

Member Eligibility Verification

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.

Possession of a Molina Medicaid ID Card does not guarantee Member eligibility or coverage. A Provider must verify a recipient's eligibility each time the recipient presents to their office for services. More information on Member eligibility verification options is available in the Eligibility, Enrollment, Disenrollment and Grace Period section of this Manual.

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Healthcare Services programs and initiatives. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Portal. Please see the Healthcare Services section of the Manual for additional details about these and other Healthcare Services programs.

In Office Laboratory Tests

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

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (Providersearch.MolinaHealthcare.com). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

Specimen collection is allowed in a physician's office and shall be compensated in accordance with your agreement with Molina Healthcare and applicable state and federal billing and payment rules and regulations. **Claims for tests performed in the physician office, but not on Molina's list of allowed in-office laboratory tests will be denied.**

Referrals

A referral is necessary when a Provider determines Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals (please refer to the Healthcare Services section of this Manual). 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 in the patient's medical record any referrals that are made. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Medicaid. In the case of urgent and 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.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

Admissions

Providers are required to comply with Molina's facility admission, prior authorization, and Medical Necessity review determination procedures.

Participation in Utilization Review and Care Management Programs

Providers are required to participate in and comply with Molina's utilization review and Care Management programs, including all policies and procedures regarding prior authorizations. This includes the use of an electronic solution for the submission of documentation required for medical review and decision making. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

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.

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.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at MolinaHealthcare.com within one (1) working day of the first prenatal visit and/or positive pregnancy test of any Member presenting themselves for healthcare services. The form should be faxed to Molina at (877) 708-2117.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Healthcare Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

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.

Additional information regarding Quality Programs is available in the Quality section of this Manual.

Access to Care Standards

Molina is committed to providing timely access to care for all Members in a safe and healthy environment. Molina will ensure Providers offer hours of operation no less than offered to commercial Members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available twenty-four (24) hours a day, seven (7) days a week to Members for Emergency Services. This access may be by telephone. For additional information about appointment access standards please refer to the Quality section of this Manual.

Site and Medical Record-Keeping Practice Reviews

As a part of Molina's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.
Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to CMS General Information, Eligibility, and Entitlement Manual, Chapter 7, Chapter 30.30 for guidance.

Delivery of Patient Care Information

Providers must comply with all State and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Molina for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina's Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction.

Compliance

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

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

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

Additionally, Providers must comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina.

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 appeals, the Provider will participate by providing medical records and/or statement as 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.

Please refer to the Complaints, Grievance and Appeals Process section of this Manual for additional information regarding this program.

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 state and federal requirements. This includes providing prompt responses to requests for information related to the credentialing or re-credentialing process.

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

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.

Section 14. Quality Improvement

Molina Healthcare of Wisconsin, Inc. maintains a Quality Improvement (QI) Department to work with Members and practitioners/providers in administering the Molina Quality Improvement Program. Providers can contact the Molina QI Department toll free at 855-326-5059 or fax 562-499- 0776. The address for mail requests is:

Molina Healthcare of Wisconsin, Inc.
Quality Improvement Department
PO Box 242480
Milwaukee, WI 53224

This Provider Manual contains excerpts from the Molina Healthcare of Wisconsin, Inc. Quality Improvement Program (QIP). For a complete copy of Molina Healthcare of Wisconsin, Inc.'s QIP providers can contact their Provider Services Representative or call the telephone number above to receive a written copy.

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

Molina Healthcare does not delegate QI activities to medical groups/IPAs. However, Molina Healthcare requires contracted medical groups/IPAs to comply with the following core elements and standards of care:

- Have a QIP in place.
- Comply with and participate in Molina Healthcare's Quality Improvement Program including reporting of access and availability and provision of Medical Records as part of the HEDIS® review process.
- Allow access to Molina Healthcare QI personnel for site and Medical Record review processes.

Relocations and Additional Sites
Providers should notify Molina Healthcare in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the provider's re-credentialing date.

Site and Medical Recordkeeping Practice Reviews
As a part of Molina Healthcare's Quality Improvement Program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record-keeping practices in their Practices. For details regarding these requirements and other Quality Improvement Program expectations, providers should review the Quality Improvement section of this manual.

Member Information and Marketing
Any written informational and marketing materials directed at Molina Healthcare Members must be developed at the sixth (6^{th}) grade reading level and have prior written consent from Molina Healthcare and the appropriate government agencies. Providers should contact their Provider Services Representative for information and review of proposed materials. Neither Molina Healthcare, nor any Participating Providers nor medical groups/IPAs may:

- Distribute to their Members informational or marketing materials that contain false or misleading information

- Distribute to their Members marketing materials selectively within the Service Area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for
- Member enrollment.

Medical Records

Medical Record Standards

Molina Healthcare 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.

Molina Healthcare conducts a Medical Record review of Primary Care Providers and women's health care providers that includes the following components:

- Medical Record confidentiality and release of Medical Records, including behavioral health care records.
- Medical Record content and documentation standards, including preventive health care. Storage maintenance and disposal.
- Process for archiving Medical Records and implementing improvement activities.

Practitioners/providers must demonstrate compliance with Molina Healthcare's Medical Record documentation guidelines. Medical Records are assessed based on the following standards:

1. **Content**
    a. Each patient has his/her own Medical Record.
    b. Chart pages are bound, clipped or attached to the file (N/A for EMR).
    c. The Medical Record is organized.
    d. Patient name or identifier is on every page.
    e. Personal biographical data is present in the chart (e.g. address, employer, home and work telephone number and marital status).
    f. All entries are signed - handwritten or initials or unique electronic identifier.
    g. All entries are dated.
    h. The Medical Record is legible to someone other than the writer.
    i. Allergies or adverse reactions are prominently noted or is there a notation NKDA or NKA.
    j. There is a complete medical history/past history for patients seen more than two (2) times.
    k. There is a social history for patients seen more than two (2) times (e.g. smoking status, drugs/alcohol, family history etc.).
    l. Significant illnesses and medical conditions are noted on a problem list.
    m. A medication list is in the Medical Record and notes the drug name, dosage, strength and the start and stop dates.
    n. The reason or chief complaint for the visit is documented.
    o. Each visit has an appropriate history and physical exam including subjective and objective information.
    p. Each visit notes a diagnosis and plan of care.

q. Follow up is noted for each patient visit.
r. Unresolved problems from previous visits are addressed in subsequent visits.
s. Laboratory, imaging, consult notes and other reports are filed in the Medical Record and are initialed by the practitioner to signify review.
t. If a consultation is requested, there is a note from the consultant in the chart; and it is initialed to signify review.
u. Therapy, home health nursing, surgery and nursing facility reports/notes are in the Medical Record (If applicable).
v. A record of Preventive Care is in the Medical Record.
w. An immunization record is present in the Medical Record.
x. Advanced directives or a discussion about advance directives are noted in the Medical Record or a copy is present in the record.
y. Medical Records are protected from unauthorized use.
z. Office uses EMR/Electronic Health Record.

2. **Organization**
   a. The Medical Record is legible to someone other than the writer.
   b. Each patient has an individual record.
   c. Chart pages are bound, clipped, or attached to the file.
   d. Chart sections are easily recognized for retrieval of information.

3. **Retrieval**
   a. The Medical Record is available to the practitioner/provider at each encounter.
   b. A copy of the Member's Medical Record is made available upon the written request of the Member or Authorized Representative and shall be provided in accordance with applicable Federal and State regulations.
   c. The Medical Record is available to Molina Healthcare for purposes of quality improvement.
   d. The Medical Record retention process is consistent with State and Federal requirements; and
   e. There is an established and functional data recovery procedure in the event of data loss.

4. **Confidentiality**
   a. Medical Records are protected from unauthorized access;
   b. Access to computerized confidential information is restricted; and
   c. Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
   d. Additional information on Medical Records is available from the provider's local Molina Quality Improvement Department toll free at 855-326-5059. Providers should also review the Health Insurance Portability and Accountability Act (HIPAA) section for additional information.

Access to Care

Molina Healthcare is committed to timely access to care for all Members in a safe and healthy Environment. Practitioners/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 95% availability for Emergency Care services and 80% 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

Office Wait Times

For scheduled appointments, wait time in offices should not exceed thirty (30) minutes from appointment time until the time seen by the PCP. All PCPs are required to monitor wait times and to adhere to this standard.

Additional information on appointment access standards is available from the provider's local Molina QI Department toll free at 855‑326‑5059.

Appointment Scheduling

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

- The practitioner must have an adequate telephone system to handle patient volume.
- Flexibility in scheduling is needed to allow for urgent walk-in appointments;
- Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services.
- 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 practitioner 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 practitioner is to notify the Molina Healthcare Member Services Department toll free at 855‑326‑5059. When the practitioner must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
- 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;
- A process for Member notification of Preventive Care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
- 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 BadgerCare Plus and/or Medicaid SSI Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and 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.

Women's Open Access

Molina Healthcare allows Members the option to seek obstetrical and gynecological care from an obstetrician or gynecologist or directly from a participating PCP designated by Molina Healthcare 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.

Additional information on access to care is available under the Health Resources tab on the MolinaHealthcare.com website or from the provider's local Molina QI Department toll free at 855-326‑

5059.

Newborn Notification Process
Physicians must notify Molina Healthcare immediately of the first prenatal visit and/or positive pregnancy test of any Member presenting herself for health care services.

The PCP shall submit to Molina Healthcare the Pregnancy Notification form within one (1) working day of the first prenatal visit and/or positive pregnancy test of any Member presenting herself for health care services. Providers shall enter all applicable information when completing the form.

The form can be found at:
http://www.MolinaHealthcare.com/providers/wi/medicaid/forms/pages/fuf.aspx and should be faxed to Molina Healthcare Member Services at 562- 499-0776.

Access Standards

Medical Appointment Type	**Time Frame**
Routine Asymptomatic Care	Within 30 calendar days
Routine Symptomatic Care	Within 14 calendar days
Urgent care	Within 24 Hours
After Hours Care	24 hours/ 7 days per week
Specialty Care	Within 21 calendar days
Urgent Specialty Care	Within 24 hours
Appointment wait time	Less than forty-five (45) minutes

Behavioral Health Appointment Type	**Time Frame**
Life Threatening	Immediately
Non-life Threatening	Within 6 hours
Urgent Care	Within 24 hours
Routine Care	Within 14 calendar days
Appointment wait time	Less than forty-five (45) minutes

Monitoring Access Standards
Molina Healthcare monitors compliance with the established access standards above. At least annually, Molina Healthcare conducts an access audit of randomly selected Participating Provider offices to determine if appointment access standards are being met. One or all of the following appointment scenarios may be addressed: routine care; acute care; Preventive Care; and after-hours information.

Results of the audit are distributed to the practitioners after its completion. A corrective action plan may be required if standards have not been met.

In addition, Molina Healthcare's Member Services Department reviews Member inquiry logs and Grievances related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available under the Resources tab at MolinaHealthcare.com or is available from the provider's local Molina QI Department toll free at 855-326-5909.

Safety

Basic emergency equipment is located in an easily accessible area. This includes:

- A pocket mask and Epinephrine, plus any other medications appropriate to the practice. At least one (I) 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.

Administration & Confidentiality

Confidential Patient check-in systems, such as:

- 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.
- There is a system in place to ensure expired sample medications are not dispensed and injectable and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Wisconsin Specific Requirements

The statewide consumer call center telephone number, including hours of operation and a copy of the summary of Wisconsin's Patient's Bill of Rights and Responsibilities are posted in the provider's waiting room/reception area. The waiting room/reception area has a consumer assistance notice prominently displayed. Providers without professional liability coverage must prominently post a sign clearly visible to all patients or provide a written statement which includes the following: "Under Wisconsin law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part- time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Wisconsin law."

Cultural and Linguistic Services

Molina Healthcare serves a diverse population of Members with specific cultural needs and preferences. Practitioners/providers are responsible to ensure that interpreter services are made available at no cost for Members with sensory impairment and/or who are Limited English Proficient (LEP).

The following cultural and linguistic services are offered by Molina Healthcare to assist both Members and practitioners/providers.

24-Hour Access to Interpreter

Practitioners/providers may request interpreters for Members whose primary language is a language other than English by calling Molina Healthcare's Member Services Department toll free at 855-326-5059. If Member Services Representatives are unable to provide the interpretation services internally, the Member and practitioner/provider are immediately connected to Language Line telephonic interpreter service.

If a patient insists on using a family member as an interpreter after being notified of his/her right to have a qualified interpreter at no cost, providers should document this in the Member's Medical Record. Molina Healthcare is available to assist providers in notifying Members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the Medical Record by stating that such counseling and treatment was done via interpreter services. Practitioners/providers should document who provided the interpretation service. That information could be the name of internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

Face-to-Face Interpreter Services

Practitioners/providers may request face-to-face interpreter services for scheduled medical visits, if required, due to the complexity of information exchange or when requested by the Member. To request face-to-face interpreter services, please contact the Quality Improvement Department. Additional information on cultural and linguistic services is available at MolinaHealthcare.com, from the provider's local Provider Services Representatives, and from the Molina Healthcare Member Services Department.

Medical Record Keeping Practice Guidelines and Compliance Standards

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

Molina Healthcare of Wisconsin, Inc. conducts a review of Member's Medical Records from all Primary Care Providers that have a fifty (50) member or more assignment against the medical record-keeping standards and requirements that are provided to them as well as other providers as determined necessary.

Practice sites include both individual offices and large group facilities.
Practice sites are scheduled for review, at a minimum, one (1) time during each two (2) year period.

Molina Healthcare of Wisconsin, Inc. reviews a reasonable number of Member's Medical Records at each site to determine compliance. A minimum of five (5) records per site is mandatory, although additional reviews are performed for large group practices or when additional data is necessary in specific instances.

Results of Medical Record reviews are assessed against Molina Healthcare of Wisconsin, Inc.'s performance goals, defined in the Medical Record documentation guidelines to identify specific practitioner deficiencies as well as opportunities for improvement throughout the network.

Overall Medical Record results are presented to the Quality Improvement Committee for determination of follow-up actions.

A review score of 80% or above is considered a passing score with no corrective action.

- Results of individual provider audits that do not meet quality standards for care or documentation are reported to the Professional Review Committee.

A review score of 79% or below requires a Corrective Action Plan (CAP) to be requested in writing from the practitioner's office.

- The CAP is due within fifteen (I5) days of notification
- If the CAP is not received within fifteen (I5) days, a second and final request is sent to the practitioner allowing an additional fifteen (I5) days
- If a CAP is not received within the total thirty (30) day timeframe, the assigned Provider
- Service Representative is notified that the practitioner is out of compliance
- Focused follow-up may include individual and organizational corrective action and general interventions designed to improve record-keeping practices.
- Practitioners who fail to receive a passing score are re-audited following implementation of corrective actions within ninety (90) days of CAP implementation.

Molina Healthcare of Wisconsin, Inc.’s performance goals are reviewed and approved annually by the Quality Improvement Committee.

Clinical Office on-site Reviews

Site and medical record keeping practice reviews

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

This includes an assessment of:

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

Adequacy of medical record keeping practices

During the site visit, Molina Healthcare discusses office documentation practices with the practitioner or

Practitioner's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and include how the practice ensures confidentiality of records. Molina Healthcare assesses medical/treatment records for orderliness of record and documentation practices. To ensure Member confidentiality, Molina Healthcare reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

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

Facility On-site Reviews

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 (2) office exam rooms per physician.

Advance Directives (Patient Self Determination Act)

Advance directives
Practitioners/providers must inform adult Molina Healthcare Members of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives. During routine Medical Record review, Molina Healthcare auditors will look for documented evidence of discussion between the practitioner/provider and the Member. Molina Healthcare will notify the provider via fax of an individual Member's advance directive 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 directive forms are State-specific to meet State regulations.

Each Molina Healthcare practitioner/provider must honor advance directives to the fullest extent permitted under law. Members may select a new PCP if the assigned provider has an objection to the beneficiary's desired decision. Molina Healthcare will facilitate finding a new PCP or Specialist as needed**.** PCPs must discuss advance directives with Members and provide appropriate medical advice if Members desires guidance or assistance. Molina Healthcare's Participating Providers are expected to communicate any objections they may have to a Member's advance directive prior to service whenever possible. In no event may any practitioner/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 Healthcare or the State survey and certification agency if the Member is dissatisfied with Molina Healthcare's handling of advance directives and/or if a practitioner/provider fails to comply with advance directive instructions.

When there is no advance directive
If there is no advance directive in place for a Member, the Member's family and practitioner 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.

Quality Improvement Activities and Programs

Molina Healthcare maintains an active Quality Improvement Program (QIP). The QIP 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.

EPSDT Services to Members Under Twenty-One (21) Years

Molina Healthcare maintains systematic and robust monitoring mechanisms to ensure all required EPSDT Services to Members under twenty-one (21) years of age are timely according to required guidelines. All Members under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program as set forth in §§1902(a)(43)and 1905(a) (4) (8) of the Social Security Act and 89 Ill. Adm. Code I40.485.

Molina Healthcare's Quality Improvement Department is 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 history
- Nutritional assessment
- Height and weight and growth charting Comprehensive unclothed physical examination Immunizations
- Laboratory procedures, including lead toxicity testing
- Periodic objective developmental screening using a recognized, standardized developmental screening tool, as approved by DCH
- Objective vision and hearing screening
- Risk assessment
- Anticipatory guidance
- Periodic objective screening for social emotional development using a recognized, standardized tool, as approved by DCH
- Perinatal depression for mothers of infants in the most appropriate clinical setting, (e.g., at the pediatric, behavioral health or OB/GYN visit)

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 Services. Members will be referred to an appropriate source of care for any required services that are not Covered Services. Molina Healthcare shall have no obligation to pay for services that are not Covered Services.

Clinical Practice Guidelines

Molina Healthcare adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-practitioner/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 appropriate established authority. Clinical Practice Guidelines are reviewed annually and are updated as new recommendations are published. Molina Clinical Practice Guidelines include the following:

- Attention-deficit/hyperactivity disorder (ADHD) Asthma
- Cholesterol
- Chronic Obstructive Pulmonary Disease (COPD) Coronary Heart Disease
- Depression Diabetes Hypertension
- Substance Abuse Treatment

The adopted Clinical Practice Guidelines are distributed to the appropriate practitioners, providers, Provider Groups, staff model facilities, delegates and Members by the Quality Improvement, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through provider newsletters, and are available on the Molina Healthcare website. Individual practitioners or Members may request copies from their local Molina QI Department **toll free at 855-326-5059.**

Preventive Health Guidelines

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

- Mammography screening;
- Prostate cancer screening;
- Cholesterol screening;
- Influenza, pneumococcal and hepatitis vaccines;
- Childhood and adolescent immunizations;
- Cervical cancer screening;
- Chlamydia screening;
- Prenatal visits.

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to practitioners/providers via MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Healthcare provider newsletter.

Measurement of Clinical and Service Quality

Molina Healthcare 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®);
- Provider Satisfaction Survey; and
- Effectiveness of Quality Improvement Initiatives.

Participating Providers must allow Molina Healthcare 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:

- Development of quality improvement activities;
- Public reporting to consumers;
- Preferred status designation in the network; and/or

- Reduced Member cost sharing.

Molina Healthcare's most recent results can be obtained from the provider's local Molina QI Department Toll free at 855-326–5059 or fax 562-499-0776.

HEDIS® Molina utilizes the National Committee for Quality Assurance (NCQA©) HEDIS as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is a set of standardized performance measures developed by NCQA which allows valid comparison across health plans. Through HEDIS®, NCQA holds Molina Healthcare accountable for the timeliness and quality of health care services (acute, preventive, mental health, etc.) delivered to Members and the provider's patients.

HEDIS® rates can be calculated in two (2) ways: administrative data or hybrid data.

Administrative
Administrative data consists of Claim or Encounter Data submitted to the Molina Healthcare and are wholly dependent upon the quality of the provider's diagnosis and procedure coding. Measures typically calculated using administrative data include: cancer and chlamydia screening, treatment of pharyngitis and depression, access to PCP services and utilization of services.

Hybrid
Hybrid data consists of both administrative data and a sample of Medical Record data. Hybrid data requires review of a random sample of the provider's Medical Records to abstract data for services rendered both that were not reported to Molina Healthcare through Claims/Encounter Data. Accurate and timely Claim/Encounter Data reduces the necessity of Medical Record review. Measures typically requiring Medical Record review include: blood pressures, diabetes care, immunizations, and prenatal care.

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, pre-natal visits, diabetes care, and cardiovascular disease.
HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare's clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs. Selected HEDIS® results are provided to regulatory and accreditation agencies as part of Molina Healthcare's contracts with these agencies. The data are also used to compare to established Molina Healthcare performance benchmarks. With increased availability of electronic Medical Records, Molina Healthcare hopes to reduce the number of charts it reviews each year for HEDIS® and rely upon queries or downloads from the provider's system. As a reminder, HEDIS® does not require a consent or authorization from the patient since protected health information (PHI) used for purposes of payment or health care operations, including quality measurement, is permitted by HIPAA Privacy Rules (45 CFR I64.506).

CAHPS

CAHPS® is the tool used by Molina Healthcare to summarize Member satisfaction with the health care and service he/she receives. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Promotion and Education, Coordination of Care and Customer Service. The CAHPS survey is administered annually in the spring to randomly selected Members by a 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 Healthcare's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

Molina Healthcare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. Molina Healthcare'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.

Definitions

Abuse – 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 standard for health care. It also includes recipient practices that result in unnecessary cost to the Medic aid programs. (42 CFR § 455.2)

Action – The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Adverse Action – A determination made in response to Grievances, Complaints or Appeals wherein Molina Healthcare's original proposed Action is upheld.

Ancillary Services – Health care services ordered by a provider, including but not limited to: Laboratory services, radiology services, and physical therapy.

Appeal – A written request by a Member or Member's Authorized Representative received at Molina Healthcare for review of an Action.

Authorization – Approval obtained by providers from Molina Healthcare for a designated service before the service is rendered. The term is used interchangeably with preauthorization or prior Authorization.

Authorized Representative – For purposes of filing a Complaint, Grievance, or Appeal, an individual appointed by the Member, including a provider or estate representative.

Centers for Medicare and Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, successor or submitted electronically.

Complaint – A general term used to describe a Member's oral expression of dissatisfaction with Molina Healthcare. It can include access problems, such as difficulty getting an appointment or receiving appropriate care; quality of care issues, such as long wait times in the reception area of a provider's office, rude providers or provider staff; or denial or reduction of a service. A Complaint may become a Grievance or Appeal if it is subsequently submitted in writing.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Covered Services – Medically Necessary services included in the State contract. Covered Services change periodically as mandated by Federal or State legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that provider status be extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.

Current Procedural Terminology (CPT) Codes - American Medical Association (AMA) Approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers' offices and home health care.

Department of Health Services (DHS) — The Wisconsin Department of Health Services, the department responsible for overseeing State-funded insurance programs.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) - Equipment used repeatedly or used primarily and customarily for medical purposes rather than for convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a provider.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any Medically Necessary services found during the EPSDT exam.

Emergency Care – The provision of Medically Necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Encounter Data - Molina Healthcare shall collect, and submit to DHS, enrollee service level Encounter Data for all Covered Services.

Excluded Providers – 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 II28 of the Social Security Act, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section II28, or has a contractual relationship with an entity convicted of a crime specified in section II28.

Expedited Appeal – An oral or written request by a Member or Member's Authorized Representative received by Molina Healthcare requesting an expedited reconsideration of an Action when taking the time for a standard resolution could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function; or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.

Expedited Grievance – A Grievance where delay in resolution would jeopardize the Member's life or materially jeopardize the Member's health.

Fee-For-Service (FFS) – A term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a Member.

Fraud – 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)

Grievance – An expression by a Member or Authorized Representative of dissatisfaction or a Complaint about any matter other than an Action. The term is also used to refer to the overlap system of Complaints, Grievances and Appeals handled by Molina Healthcare. Possible Grievance subjects include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights.

Healthcare Effectiveness Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPAA – The Health Insurance Portability and Accountability Act of 1996.

Independent Practice Association (IPA) – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one (I) or more health plans.

Medicaid – The State and federally funded medical program created under Title XIX of the Social Security Act.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the Member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a Member.

Medically Necessary or **Medical Necessity** – Services that include medical or allied care, goods or services furnished or ordered that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
- Consistent with the generally accepted professional medical standards as determined by applicable
- Federal and State regulation or law, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the Member, the
- Member's caretaker, or the provider.

Medicare – The Federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two (2) parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

Participating Provider – A provider that has a written agreement with Molina Healthcare to provide services to Members under the terms of his/her agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) –A Participating Provider responsible for supervising, coordinating, and providing primary health care to Members, initiating Referrals for Specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to; pediatricians, family practice providers, general medicine providers, internists, obstetrician/gynecologists, physician assistants (under the supervision of a physician), or advanced registered nurse practitioners (ARNP), as designated by Molina Healthcare.

Provider Group – A partnership, association, corporation, or other group of providers.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Referral – The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.

Remittance Advice (RA) – Written explanation of processed Claims.

Service Area – A geographic area serviced by Molina Healthcare, designated and approved by DHS.

Specialist – Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

State Children's Health Insurance Plan (SCHIP) – A Federal/State funded health insurance program authorized by Title XXI of the Social Security Act and administered by DHS.

Sub-Contract – A written agreement between Molina Healthcare and a Participating Provider, or between a Participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations Molina Healthcare is required to perform pursuant to the agreement.

Supplemental Security Income (SSI) –A Federal cash program for aged, blind, or disabled persons, administered by the SSA.

Title XIX – The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the Federal Social Security Act that authorizes grants to states for SCHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge Planning and case management.

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