

PROVIDER MANUAL

Molina Healthcare of Nebraska, Inc.

Heritage Health

Unless defined herein, capitalized words or phrases used in this Provider Manual shall have the same meaning set forth in your Provider Agreement with Molina Healthcare of Nebraska, Inc. or "Molina" has the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated bi-annually but may be updated as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com. A printed copy of this Provider Manual is available to Providers at no charge by contacting Molina at NEProviderRelations@MolinaHealthcare.com.

EFFECTIVE DATE: January 1, 2024

MOLINA HEALTHCARE | HERITAGE HEALTH

Molina Healthcare of Nebraska, Inc.
Medicaid Provider Manual Addendum – July 2024

Section Title: Benefits and Covered Services

Subsection Title: Hospice Services

The following language will be updated:

Current Language

Hospice services are covered when they are ordered by a physician and performed by a Medicare-certified hospice provider enrolled as a Medicaid provider. Hospice services require prior authorization. Hospice services focus on supportive care, comfort, and quality of life for those Members in the final phase of a terminal illness. Molina's Care Management team will review a Member's Individualized Care Plan (ICP), which includes a Member's desire for hospice services, palliative care and support to determine authorization.

New Language (refer to language in blue font)

Hospice services are covered when they are ordered by a physician and performed by a Medicare-certified hospice provider enrolled as a Medicaid provider. Hospice services require prior authorization after the initial 60-day period. Hospice services focus on supportive care, comfort, and quality of life for those Members in the final phase of a terminal illness. Molina's Care Management team will review a Member's Individualized Care Plan (ICP), which includes a Member's desire for hospice services, palliative care and support to determine authorization.

Molina Healthcare of Nebraska, Inc.
Medicaid Provider Manual Addendum – July 2024

Section Title: Compliance

Subsection Title: Post-payment Recovery Activities

The following language will be updated:

Current Language

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

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

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

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

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

New Language (refer to language in blue font)

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

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

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

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

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Molina Healthcare of Nebraska, Inc.
Medicaid Provider Manual Addendum – July 2024

Section Title: Claims and Compensation

Subsection Title: Required Elements

The following language will be updated:

Current Language

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at EDI > Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan-specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to-Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), the unit of measure and quantity for medical injectibles
- E-signature
- Service Facility Location information

- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and applies to atypical and out-of-state Providers. **Provider information submitted on the Claim must match the information on file with the Nebraska Medicaid and Long-Term Care Division (MLTC) in order for Claim payment to be made**. Changes to Provider information should be made to MLTC's Maximus Provider Enrollment Platform prior to claim submission to Molina.

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

New Language (refer to language in blue font)

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at EDI > Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan-specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

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- Valid Diagnosis Pointers
- Total billed charges
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- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to-Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans

- National Drug Code (NDC), NDC Units, Units of Measure and Days or Units for medical injectibles
- E-signature
- Service Facility Location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and applies to atypical and out-of-state Providers. **Provider information submitted on the Claim must match the information on file with the Nebraska Medicaid and Long-Term Care Division (MLTC) in order for Claim payment to be made**. Changes to Provider information should be made to MLTC's Maximus Provider Enrollment Platform prior to claim submission to Molina.

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

Molina Healthcare of Nebraska, Inc.
Medicaid Provider Manual Addendum – July 2024

Section Title: Claims and Compensation

Subsection Title: Overpayments and Incorrect Payments Refund Requests

The following language will be updated:

Current Language

If, as a result of a retroactive review of the Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an Overpayment request letter if the Overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

- Submit a refund to satisfy Overpayment.
- Submit a request to offset from future Claim payments.
- Dispute Overpayment findings.

Instructions will be provided on the Overpayment notice, and Overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling, including the policy number, effective date, term date, and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. For Members with Medicare COB, Molina will provide notice within 540 days from the Claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the Claim and pay or deny the Claim in accordance with Claim processing guidelines.

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 paid 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.

Overpayment Disputes should be received within thirty (30) days of the Overpayment notification letter. Overpayment Disputes should be sent to the address listed on the Overpayment notification. Overpayment Disputes can also be submitted via the Availity Essentials portal at Provider.MolinaHealthcare.com.

New Language (refer to language in blue font)

In accordance with 42 CFR 438.608, Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

If, as a result of a retroactive review of the Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an Overpayment request letter if the Overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

- Submit a refund to satisfy Overpayment.
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INTRODUCTION

Molina Healthcare of Nebraska, Inc. (Molina) is a wholly owned subsidiary of Molina Healthcare, Inc. (Molina Healthcare), an experienced leader in providing quality health care for government-sponsored programs. Molina Healthcare's subsidiary Medicaid health plans are member-centered, community focused, and cost-effective, and have consistently shown meaningful gains in Member access to care and health outcomes for almost thirty (30) years. Molina was selected by the Department of Health and Human Services (DHHS), Division of Medicaid & Long-Term Care (MLTC) to serve enrollees in Nebraska's Heritage Health program, which is a health care delivery system that combines Nebraska's physical health, behavioral health, pharmacy, and dental programs into a single comprehensive and coordinated system for Nebraska's Medicaid and CHIP clients.

This Provider Manual contains comprehensive information about Molina Heritage Health (Medicaid) operations, benefits, billing, policies, procedures, and how we partner with our network of Providers. The most current version is always available on our website at MolinaHealthcare.com. You will be notified of updates through the "significant changes" document posted on the website with new versions of the manual as well as BlastFax, Provider Bulletins, Provider Network Email, and Quarterly Provider Newsletter. Minor updates will be made available as an addendum at the front of the manual and notifications will be provided when updates are made. Note: For information related to other lines of business (e.g. Medicare, etc.) please access the business-specific line of business in the Molina Healthcare of Nebraska Provider Manual.

CONTACT INFORMATION

This section includes important telephone and fax numbers available to your office. When calling Molina, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID (TIN) number
- Member's ID number or Medicaid ID number

Physical Address

Molina Healthcare of Nebraska, Inc.
14748 W Center Rd, Suite 104
Omaha, NE 68144

Provider Services Department

The Provider Services department conducts Provider trainings and responds to all telephone inquiries from Providers, including policy and procedure questions, claims issues, and contracting questions. The department has Provider Relations representatives, who serve all of Molina's Provider network and products.

The Provider Services department is available to Providers Monday – Friday 7 a.m. – 6 p.m. Central Time, except for state holidays.

Phone: (844) 782-2678
Fax: (833) 929-3006

Molina has assigned Provider Relations representatives by region to enable Providers to receive prompt resolution of any problems or inquiries and to receive education about Molina's Healthcare program. An up-to-date Provider Relations representative map and contact information is available on our Provider website at MolinaHealthcare.com/NEProviders under the "Provider Resources" tab.

Our Provider website is located at MolinaHealthcare.com/members/ne/en-US/pages/home.aspx which features our Provider Online Directory, Preventative & Clinical Care Guidelines, Provider Manual, Web Portal, Prior Authorization Look-up Tool, Advanced Directives, Behavioral Health Toolkit, Claims Information, Pharmacy Information, HIPAA, Fraud Waste & Abuse Information, Frequently Used Forms, Communications and Newsletters as well as Contact Information.

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information at least once every three (3) years, or sooner. The

information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network. For additional information on Molina's Credentialing program, including Policies and Procedures, please refer to the Credentialing and Recredentialing section of this Provider Manual. For credentialing questions please send your inquiries to NENetwork@MolinaHealthcare.com or call (844) 782-2678 Monday – Friday 7 a.m. – 6 p.m. Central Time, except for state holidays.

Health Care Services Department

The Utilization Management team employes licensed medical and behavioral professionals who conduct concurrent review on inpatient cases and process prior authorization service requests.

The Care and Case Management team assist Members who have identified complex condition(s) and needs including Social Determinants of Health (SDOH). Care and Case Managers are licensed medical and behavioral health professionals who will assist members with accessing care and support services.

Participating Providers are required to interact with Molina's Health Care Services (HCS) department electronically whenever possible. To submit a prior authorization request or to refer a Member for Care or Case Management services you may submit a referral through the Availity Essentials Portal. Prior authorizations/service requests and status checks can be easily managed electronically.

Molina 's HCS department operating hours are Monday – Friday, 8 am – 5 pm central time.

To contact HCS, please call (844) 782-2678 or fax (833) 832-1015.

To contact Care and Case Management services or to make a referral please send email to .

Disease Management

Molina's Disease Management provides programs to help Members and their family in better understanding their health conditions. Members may receive a call from a case manager (nurse and registered dietician) who can provide Members with education and support based on their health care needs. Health education materials can also be sent to Members based on goals set by Members and their case manager.

Phone: (833) 269-7830
Fax: (800) 642-3691

How do Members enroll?

To join a program, Members must meet certain requirements. Members who meet the requirements are enrolled automatically.

Molina uses the following information to identify Members for our Health Management programs:

- Claims
- Pharmacy
- Other health management programs
- Members can self-refer to a program, or Providers may refer Members. Members can request to be removed at any time.

The programs available to Members at no cost include:

Molina My Health – Tobacco Cessation Program

Adult members, age eighteen (18) and older, who are ready to try and quit tobacco use will work directly with a trained Health Educator to:

- Make an individualized tobacco cessation plan of care
- Get support throughout the quit process

Other resources to help quit smoking:

- Quit for Life®: Call (866) QUIT-4-LIFE (or (866) 784-8454), or visit quitnow.net
- Smokefree.gov

Molina My Health – Weight Management Program

For adult Members, age eighteen (18) and older, who are interested in losing weight (except for those scheduled for bariatric surgery). A Case Manager will:

- Work together to develop a weight management plan of care
- Make sure the plan of care is individualized to meet Member needs
- Help reach Member weight loss goals

Molina My Health – Nutrition Consult Program

Molina offers a Nutrition Consultation Program to support Members' nutrition health needs. A Registered Dietitian will work closely with them to:

- Understand Members' health concerns
- Work together to develop an individualized plan of care
- Provide Members with tools and aids to better self-manage their health condition

Molina My Health – Living with Asthma

For child and adult members, age two (2) and older, who have a diagnosis of asthma. A Case Manager will help Members:

- Understand and identify their symptoms

- Avoid triggers that increase symptoms
- Understand their prescribed asthma medications

Molina My Health – Living with Diabetes

For adult Members, age eighteen (18) and older, who have a diagnosis of diabetes. Members will work with their Case Manager and learn about:

- Healthy eating
- The importance of checking their blood sugar and knowing their hemoglobin A1c level
- The value of daily activity
- Following the diabetes self-management plan outlined by their Provider

Molina My Health – Living with Heart Failure

For adult Members, age eighteen (18) and older, who have a diagnosis of heart failure. Members will learn from their Case Manager about:

- Heart-healthy eating
- Monitoring their weight
- Reporting symptom changes to the Provider
- The importance of daily activity and taking medications as prescribed

Molina My Health – Living with Depression

For adult Members, age eighteen (18) and older, who either have a diagnosis of depression or may be having symptoms of depression. The program is designed to:

- Promote early identification of symptoms
- Provide education, guidance, and support
- Teach life coping skills
- Share available services, treatment options, and community support

Molina My Health – Living with COPD

For adult Members, age eighteen (18) and older, who have a diagnosis of COPD. Members will learn from their Case Manager about:

- Breathing exercises
- Planning and pacing activities
- Oxygen-related safety measures
- The importance of taking medications as prescribed

Molina My Health – Living with Hypertension

For adult Members, age eighteen (18) and older, who have a diagnosis of high blood pressure. Members will learn from their case manager about:

- Health-healthy eating
- Monitoring blood pressure
- The importance of daily activity
- The importance of taking medications as directed

RIGHTS AND RESPONSIBILITIES

Provider Rights

Providers have the right to:

- Be treated by their patients and other health care workers with dignity and respect.
- Receive accurate and complete information and medical histories for Members' care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Expect other network Providers to act as partners in Members' treatment plans.
- Expect Members to follow their directions.
- File a complaint/grievance or file a Claim appeal against Molina.
- File a grievance with Molina on behalf of a Member, with the Member's consent.
- File an appeal with Molina on the behalf of the Member, with the Member's consent.
- Have access to information about Molina quality improvement programs, including program goals, processes, and outcomes that relate to Member care and services.
- Contact the Molina Provider Services department with any questions, comments, or problems.
- Collaborate with other health care professionals who are involved in the care of Members.

Provider Responsibilities

Mainstreaming

Molina considers mainstreaming of its Members as an important component of the delivery of care. Molina expects its participating Providers to treat Members without regard to pay source, race, color, creed, sex, religion, age, national origin (including those with limited English proficiency), ancestry, marital status, sexual preference, gender identity, health status, genetic information, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a Member a covered service or availability of a facility.
- Providing a Molina Member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay Members (examples: different waiting rooms or appointment times or days), except where medically necessary.
- Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any covered service; or restricting a Member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service.
- Assigning times or places for provision of services based on the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, gender identity, income status, Medicaid membership, or physical or mental illnesses of the participants served.

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

All Molina Providers shall disclose all complaints of discrimination in violation of Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.

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

Toll Free: (866) 606-3889
TTY/TDD: 711

Online: MolinaHealthcare.AlertLine.com

Email: civil.rights@MolinaHealthcare.com

Should you or a Molina Member need more information, you can refer to the Health and Human Services website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

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 Members and Provider Network.

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/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate their Provider information on file with Molina **at least** once every ninety (90) days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum thirty (30) calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Change in specialty.
- Any other information that may impact Member access to care.

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Please visit our Provider Online Directory at MolinaProviderDirectory.com/NE to validate your information. Providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice. Providers unable to make updates through the CAQH portal, or roster process, should contact their Provider Relations representative for assistance.

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 and Recredentialing section of this Provider Manual.

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

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider can attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

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

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

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Availity Essentials portal.

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

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Availity Essentials portal

Electronic Claims Submission Requirement

Molina strongly encourages Participating Providers to submit Claims electronically whenever possible.

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity Essentials portal.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID MLNNE, refer to our website MolinaHealthcare.com for additional information.

For additional information on EDI Claims submission, please refer to the Claims and Compensation section of this Provider Manual.

Electronic Payment Requirement

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

Molina Healthcare contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform, you may receive your payment via EFT/ACH, a physical check, or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via virtual card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt-out of receiving a virtual card prior to your first payment, you may contact ECHO Customer Service and request that your Tax ID for payer Molina Healthcare of Nebraska be opted out of virtual cards.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your Practice Management System is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal (providerpayments.com).

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting ECHO Customer Service.

As a reminder, Molina's Payer ID is MLNNE.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two (2)-year lookback.

ECHO Customer Service Phone: (888) 834-3511
ECHO Customer Service Hours of Operation: 8 a.m. - 6 p.m. EST
ECHO Customer Service Email: edi@echohealthinc.com

Additional instructions on how to register are available under the "EDI/ERA/EFT" tab on Molina's website at MolinaHealthcare.com.

Paper Claim Submissions

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

Molina Healthcare of Nebraska, Inc.
PO Box 93218
Long Beach, CA 90809-9994

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box. Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either ten (10) or twelve (12) point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

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

Availity Essentials Portal

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

- Verify Member eligibility, Covered Services, and view HEDIS® needed services (gaps)
- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS- CMS-1450 [UB04]) Claims with attached files
  - Correct/Void eligible Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage Claim Templates
  - Create and submit a Claim Appeal with attached files
  - Manage Molina initiated overpayments
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
- Download forms and documents
- Send/receive secure messages to/from Molina

Not registered with Availity Essentials?

- If your organization is not yet registered for Availity Essentials and you're responsible for the registration, please visit Availity.com/MolinaHealthcare and click the Register button.
- For registration or other issues, call Availity Client Services at (800) AVAILITY (282-4548). Assistance is available Monday-Friday 8 a.m. to 8 p.m. EST.
- Dive Deeper into Essentials
- Once you have your Availity Essentials account, you can learn more about the features and functionality offered for Molina providers. Simply log in > go to Help & Training > Get Trained to register for a webinar.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. As described in your Agreement with Molina Healthcare of Nebraska, balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Marketing Rules and Guidelines

- When conducting any form of marketing in a provider's office, Molina will obtain and keep on file the written consent of the Provider.
- Molina does not require its Provider to distribute Molina-prepared marketing communications to the Member.
- Molina does not provide incentives or giveaways to Providers to distribute marketing materials to Molina Members or potential Molina Members.
- Molina prohibits Providers from soliciting enrollment or disenrollment in a particular Managed Care Organization (MCO) or to distribute MCO-specific materials.
- Molina is prohibited from providing printed materials to Providers with instructions on how to change a Member to another MCO.
- Participating Providers who wish to let their patients/Members know of their affiliations with one or more Managed Care Organization (MCO) must list each MCO with whom they contract.
- Participating Providers may display and distribute health education materials for all contracted MCOs or they may choose not to display and distribute for any contracted MCOs. Health education materials must adhere to the following guidance:
  a.) Health education posters cannot be larger than 16 x 24 inches.
  b.) Children's books, donated by MCOs, must be in common areas; and
  c.) Materials may include the MCO's name, logo, telephone number and website address.
- Providers are not required to distribute and/or display all health education materials provided by each MCO with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted MCO and that the distribution and quantity of items displayed are equitable.
- Providers may display marketing materials for MCOs provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom/which the Provider has a contract.
- Providers may display MCO participation stickers but must display stickers for all contracted MCOs or choose not to display stickers for any contracted MCOs.
- MCO stickers indicating that the Provider participates with a particular MCO cannot be larger than 5 x 7 inches and cannot indicate anything more than "The MCO is accepted or welcomed here."
- Providers may inform their patients of the benefits, services, and specialty care services offered through the MCOs in which they participate. However, Providers may not recommend one MCO over another, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including, but not limited to, using a phone, computer, or fax machine in the office.
- On actual termination of a contract with the MCO, a Provider who/that has contracts with other MCOs may notify their patients of the change and the impact of the change on the patient, including the date of the contract termination. Providers must continue to see

current patients enrolled in the MCO through the termination date, according to all terms and conditions specified in the contract between the Provider and the MCO.

Please contact your Provider Relations representative with questions or for information and review of proposed materials.

Member Cost

Providers should verify the Molina Member's cost share status prior to requiring the Member to pay copay, coinsurance, deductible or other cost share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost share that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

Health Care Services (Utilization Management and Care/Case Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care/Case Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, Medical Necessity review determination, and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of Covered Services. Molina has Case Managers available to assist Molina Members with chronic disease, SDOH, complex medical conditions, special health care needs, or those Members you feel may need a helping hand managing their care. Providers, including Dentists, are encouraged to make Member referrals to Molina's Care/Case Management staff. Referrals can be made through the Availity Essentials portal.

For additional information please refer to the Health Care Services section of this Provider Manual

Referrals

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

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

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

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

Treatment Alternatives and Communication with Members

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

Pharmacy Program

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

Participation in Quality Programs

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

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

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

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

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

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or appeals. If a Member has a grievance regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed.

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

Record Retention

Providers are required to maintain and retain Member records for a period of not less than ten (10) years and retain further if the records are under review or investigation until such time that the review or investigation is complete.

Participation in Credentialing

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

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

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

Delegation

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

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists Participating with Molina
- Triage appropriately
- Notify Molina of Members who may benefit from Case Management

- Participate in the development of Case Management treatment plans

Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined below:

Members have the right to:

- Be treated with courtesy and respect, with appreciation of their individual dignity, and with protection of their need for privacy.
- Request and obtain information on any limits of their freedom of choice among network Providers.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for their care.
- Know what patient support services are available, including whether an interpreter is available if they do not speak English.
- Know what rules and regulations apply to their conduct.
- Receive information in a manner and format that may be easily understood.
- Be given, by a health care Provider, information concerning diagnosis, planned course of treatment, treatment options, alternatives, risks, and prognosis in a manner appropriate to their condition and ability to understand.
- Be able to take part in decisions about their health care.
- Have an open discussion about their medically necessary treatment options for their conditions, regardless of cost or benefit.
- Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- Request and receive a copy of their medical records, and request that they be amended or corrected.
- Request disenrollment.
- Be furnished health care services in accordance with Federal and State regulations.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information, and necessary counseling on the availability of known financial resources for their care.
- If Members are eligible for Medicare, to know, upon request and in advance of treatment, whether the health care Provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a reasonably clear and understandable itemized bill
- Have their bill and medical charges explained, upon request.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, disability, or source of payment.

- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give their consent or refusal to participate in such experimental research.
- Receive information about Molina, its services, its Practitioners and Providers and Members' rights and responsibilities.
- Exercise these rights without an adverse effect in the way Molina and its Providers treat them.
- Receive information about the structure and operation of Molina.
- Make recommendations about Molina's Member rights and responsibilities policies.
- Voice complaints or appeals about the organization or the care it provides.
- Express grievance regarding any violation of their rights, through the grievance procedure of the health care Provider or health care facility which served them and to the appropriate State licensing agency listed below:

  Nebraska Department of Health and Human Services
  MLTC Appeal Coordinator
  PO Box 94967
  Lincoln, NE 68509-4967

Members are responsible for:

- Providing to the health care Provider, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health.
- The cost of unauthorized services obtained from non-participating Providers.
- Reporting unexpected changes in their condition to the health care Provider.
- Reporting to the health care Provider whether they comprehend a contemplated course of action and what is expected of them.
- Follow the care plan that they have agreed on with their Provider.
- Keeping appointments and, when they are unable to do so for any reason, to notify the health care Provider or health care facility.
- Their actions if they refuse treatment or do not follow the health care Provider's instructions.
- Assuring that the financial obligations of their health care are fulfilled as promptly as possible.
- Following health care facility rules and regulations affecting patient care and conduct.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Report truthful and accurate information when applying for Medicaid. (They will be responsible to repay capitation premium payments if their Enrollment is stopped due to failure to report truthful or accurate information.)

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

For additional information, please contact Molina at (844) 782-2678, 7 a.m. – 6 p.m. Central Time, Monday – Friday excluding state holidays. TTY/TDD users, please call 711.

Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Molina Member Services to find out how to get a second opinion. Molina will coordinate the second opinion with an in-network Provider. If a qualified specialty care Provider is not available within the network, Molina will coordinate and authorize the second opinion with an out-of-network Provider.

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 U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all implementing regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability.

Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com.

Nondiscrimination in Health Care Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider Participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State Law; and Federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.

2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post is available on our Provider website at MolinaHealthcare.com/providers/ne/medicaid/resources/forms.aspx.

3. You **MUST** post in a conspicuous location in your office, a Tagline Document, which explains how to access non-English language services. A sample of the Tagline Document that you will post is available on our Provider website at https//www.MolinaHealthcare.com/providers/ne/medicaid/resources/forms.aspx.

4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html. See also hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.

5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD: 711 Civil.Rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a Molina Member needs additional help or more information, call (800) 368-1019 or TTY/TDD (800) 537-7697.

Cultural Competency

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

Provider and Community Training

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

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

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

Integrated Quality Improvement – Ensuring Access

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

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

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

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Provider Services helpline toll free at (844) 782-2678. If Provider Services helpline representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified language service provider.

Molina Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Molina Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

Documentation

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

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

Members Who Are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member Services, Quality, Health Care Services and all other health plan functions.

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

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

Nurse Advice Line

Molina provides Nurse Advice Services for Members 24 hours per day, 7 days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: (844) 782-2721 or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:

    - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
    - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS® results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

ENROLLMENT AND ELIGIBILITY

Enrollment

Enrollment in Medicaid Programs

The Nebraska Department of Health and Human Services (DHHS) administers and manages eligibility for Medicaid programs through ACCESSNebraska. Details on how individuals can apply for benefits are available on the ACCESSNebraska website. Medicaid and CHIP eligibility renewals are conducted annually.

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

Effective Date of Enrollment

The effective date of enrollment with Molina is typically the first day of the month of the Member's eligibility for Medicaid. In some cases, an individual may be retroactively eligible for Medicaid, in such cases the first day of eligibility is the date of the Member's eligibility effective date with DHHS.

Newborn Enrollment

Providers must report births of Members to Molina within twenty-four (24) hours of the birth. Once the Medicaid and Long-Term Care (MLTC) eligibility is updated with a record of the live birth, the newborn will be immediately enrolled in either the mother's or an eligible sibling's MCO.

Inpatient at time of Enrollment

Molina is responsible for covered benefits and services in the core benefit package from and including the effective date of a Member's Medicaid eligibility for any month the Member is enrolled with Molina. If the Member's length of stay for an inpatient admission includes any dates in which the Member is enrolled with Molina, Molina is responsible for the inpatient stay.

Eligibility Verification

Medicaid Programs

Nebraska DHHS determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Medicaid Programs

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

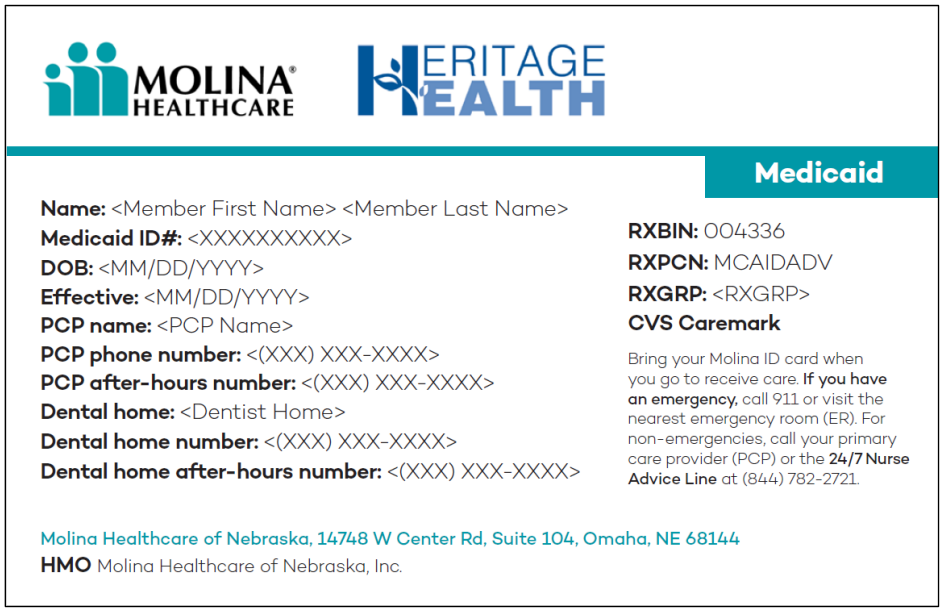
- Molina Provider Services automated IVR system at (844) 782-2678
- Availity Essentials portal at Provider.MolinaHealthcare.com
- Nebraska Medicaid Eligibility System (NMES) at (402) 471-9580 or (800) 642-6092

If the above options do not sufficiently verify Member eligibility, Providers may speak to a representative at the Provider Services helpline at (844) 782-2678.

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

Identification Cards

"Molina Sample Member ID Card



Members are reminded in their Member Handbooks to present ID cards when requesting medical or pharmacy services. The Molina ID card can be a physical or digital ID card. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment prior to rendering services. Unless an Emergency Medical Condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

PCP Assignment

Molina Members are allowed to select an in-network PCP at the time of enrollment. If no PCP is selected, one will be assigned.

PCP Changes

Members may change their PCP at any time. Members who wish to change their PCP may call Molina Member Services at (844) 782-2018. Members may also manage their health care at any time via the Member Portal available at MyMolina.com. Members may use the Member Portal to change their PCP, update their contact information, request a new ID card and view service history.

BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Heritage Health Members. Some benefits may have limitations, which may not all be outlined in the summary table below. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools on the Molina website and the Availity Essentials portal. You may also contact Molina at (844) 782-2678, 7 a.m. – 6 p.m. Monday – Friday, excluding state holidays.

Member Cost

Cost share is the deductible, copayment, or coinsurance that Members must pay for Covered Services provided under their Molina plan. The cost share amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card.

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

Services Covered by Molina

Molina covers, at a minimum, core benefits and services specified in our Agreement with Nebraska DHHS and defined in the Nebraska Medicaid administrative rules, and Department policies and procedure handbook. Please refer to the Nebraska Medicaid website for additional information: dhhs.ne.gov/Pages/medicaid-and-long-term-care.aspx.

Members under the 599 CHIP program have access to a limited set of Covered Services. These services include prenatal care and pregnancy-related services solely for the health of the unborn child. It does not cover postpartum care and medical issues separate from the pregnant woman's health and unrelated to the pregnancy.

If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools on the Molina website and the Availity Essentials portal. You may also contact Molina at (844) 782-2678, 7 a.m. – 6 p.m. Monday – Friday, excluding state holidays.

Link(s) to Summary of Benefits

The following web link provides access to basic benefit information for the Heritage Health program offered by Molina in Nebraska:

MolinaHealthcare.com/members/ne/en-us/mem/Medicaid/benefits.aspx

All value-added benefits and rewards may have exclusions or limits. Members must have Molina Healthcare of Nebraska Medicaid as their primary insurance at the time of service to qualify for value-added benefits and rewards.

Services Not Covered by Molina

Excluded Services

Excluded services are those services for which Molina is not financially responsible, but the Member may obtain under the Nebraska Medicaid State Plan. These services will be paid for by the Division of Medicaid and Long-Term Care (MLTC) on a fee-for-service basis. Excluded services include:

- Intermediate care facility services for individuals with developmental disabilities.
- Institutional long-term care/nursing facility services at a custodial level of care.
- School-based services.
- Home and Community-Based Services (HCBS) waiver services.
- Nebraska Medicaid Personal Assistance Services.

Prohibited Services

Prohibited services are those required to treat complications or conditions resulting from non-Covered Services, services not reasonable and necessary, and services that are experimental and investigational unless approved by the MLTC Director.

All services described in Section 1903(i) of the Social Security Act are prohibited services.

Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process

The Provider may request a prior authorization for clinically appropriate drugs that are not preferred under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within twenty-four (24) hours of receiving the complete request.
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within twenty-four (24) hours of receiving the complete request.
- Members will also have the right to appeal a denial decision per any requirements set forth by MLTC.
- Molina will allow a seventy-two (72)-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available. Pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the

seventy-two (72)-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

All drugs administered and billed require the appropriate National Drug Code (NDC) to be present on the claim to be considered for payment.

Specialty Drug Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor designated by Molina. More information about our prior authorization process, including a link to the Prior Authorization Request Form, is available in the Health Care Services section of this Provider Manual.

All administered drugs administered and billed require the appropriate National Drug Code (NDC) to be present on the claim to be considered for payment.

Injectable and Infusion Services

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

Family planning services related to the injection or insertion of a contraceptive drug or device are covered.

All drugs administered and billed require the appropriate National Drug Code (NDC) to be present on the claim to be considered for payment.

Access to Behavioral Health Services

Behavioral Health services are a direct access benefit and are available with no referral required. PCPs may assist Members in finding a behavioral health Provider, or Members may contact Molina's Provider Services helpline at (844) 782-2018. Molina's Nurse Advice Line is available 24 hours a day, seven days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential.

Additional details regarding Covered Services and any limitations can be obtained in the benefit information provided above or by contacting Molina. If inpatient services are needed, prior authorization must be obtained, unless the admission is due to an emergency, and inpatient Member cost share will apply.

Emergency Mental Health or Substance Abuse Services

Members are directed to call 988, 911, or go to the nearest emergency room if they need Emergency mental health or substance abuse services. Examples of emergency mental health or substance abuse problems are:

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

Out-of-Area Emergencies

Members having a health emergency who cannot get to a Molina approved Provider are directed to do the following:

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

For out-of-area Emergency Services, out-of-network Providers are directed to call the Molina contact number on the back of the Member's ID card for additional benefit information and may be asked to transfer Members to an in-network facility when the Member is stable.

Emergency Transportation

When a Member's condition is life-threatening and requires the 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

Molina Heritage Health Members have non-emergency medical transportation as a Covered Service. Medicaid covers the most appropriate non-emergency transportation (NET) services necessary to obtain Nebraska Medicaid reimbursed services when one of the following criteria is met:

- Member does not own or does not have access to a working licensed vehicle.
- Member does not have a current valid driver's license.
- Member is unable to drive due to a documented physical, cognitive, or developmental limitation.
- Member is unable to travel or wait by himself or herself due to a documented physical, cognitive, or developmental limitation.
- Member is unable to secure free transportation.

Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair-accessible vans.

Molina partners with our vendor, MTM, to provide non-emergency medical transportation (NEMT). Prior authorization is not required for non-emergency medical transportation (i. e., vans, taxis, etc.); however, prior authorization from Molina for ground and air ambulance services is required before the services are rendered. Additional information regarding the availability of this benefit is available by contacting Provider Services at (844) 782-2678.

Preventive Care

Preventive Care Guidelines are located on the Molina website. Please use the link below to access the most current guidelines:
MolinaHealthcare.com/providers/ne/medicaid/health/guide_preventive.aspx

We need your help conducting these regular exams to meet the targeted State and Federal standards. If you have questions or suggestions related to well-child care, please call our Health Education line at (866) 891-2320.

Immunizations

Molina Members may receive immunizations as recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices and prescribed by the Member's PCP.

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

Molina covers immunizations not covered through Vaccines for Children (VFC). However, for vaccines available through the VFC program, Providers are reimbursed for the administration of the vaccine only in accordance with VFC program requirements.

Providers are required to report all administered vaccination data to the Nebraska State Immunization Information System (NESIIS) administered through the DHHS/Division of Public Health.

Well Child Visits and EPSDT Guidelines

Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) is a comprehensive and preventive child health program for Members under the age of twenty-one (21) years. The EPSDT statute and Federal Medicaid regulations require that states cover all services within the scope of the Federal Medicaid program, including services not included in the state's Medicaid State Plan, if necessary, to correct or improve a known medical condition (42 USC § 1396d(r)(5) and the CMS Medicaid State Manual).

The EPSDT program consists of two mutually supportive operational components:

- Ensuring the availability and accessibility of required health care services
- Helping Medicaid Members and their parents or guardians effectively use these services

The intent of the EPSDT program is to direct attention to the importance of preventive health services and detection and treatment of identified problems.

The EPSDT benefit requires the provision of early and periodic screening services and well-care examinations to individuals from birth until twenty-one (21) years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and periodicity schedule generally follow the recommendations from the AAP and Bright Futures.

The screening services include:

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

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

We need your help conducting these regular exams to meet the MLTC targeted State standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well-child care, please call our Health Education line at (866) 891-2320.

Prenatal Care

Stage of Pregnancy	How often to see the doctor
1 month – 6 months	1 visit a month
7 months – 8 months	2 visits a month
9 months	1 visit a week

Emergency Services

Emergency Services means covered inpatient and outpatient services that are as follows:

- Furnished by a Provider that is qualified to furnish these services under Title 42 CFR
- Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergent Services are covered by Molina without prior authorization. This includes non-contracted Providers inside or outside of Molina's service area. Molina will reimburse non-contracted Providers for emergency medical services at no less than the Nebraska Medicaid FFS (Fee For Service) rate in effect on the Date of Service. Molina will not deny payment for treatment obtained when a Member has an Emergency Medical Condition as defined in 42 CFR § 438.114(a) and/or 42 CFR § 438.114(c)(1)(ii)(A), or when a representative of Molina instructs the Member to seek Emergency Services. Molina will not limit what constitutes an Emergency Medical Condition based on diagnoses or symptoms. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to stabilize and diagnose the specific condition.

Molina will not refuse to cover Emergency Services based on the emergency department Provider, hospital, or fiscal agent failing to notify the Member's primary care Provider, Molina, or applicable state entity of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. Emergency medical services and post-stabilization services are reimbursed at 100% of the current Medicaid FFS rate on the date of service.

A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to stabilize and diagnose the specific condition.

Post-Stabilization

Molina will provide coverage for post-stabilization care services as specified in 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(i), (ii) and (iii), regardless of whether the Provider who furnishes the services is contracted or non-contracted Providers inside or outside of Molina's service area.

Molina covers post-stabilization care services if they are:

- Pre-approved by a network Provider or other Molina representative; or
- Not pre-approved by a network Provider or other Molina representative, but:
    - Administered to maintain the Member's stabilized condition within one (1) hour of a request to Molina for prior authorization of further post-stabilization care services, or
    - Administered to maintain, improve, or resolve the Member's stabilized condition, and:
        - Molina did not respond to a request for prior authorization within one (1) hour.
        - Molina cannot be reached.
        - Molina representative and the treating physician cannot reach an agreement regarding the Member's care and a network physician is not available for

consultation. In this situation, Molina will give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of 42 CFR § 422.133(c)(3) is met.

- Molina's financial responsibility for post-stabilization care services that have not been pre-approved ends when:
  - A contracted Provider with privileges at the treating hospital assumes responsibility for the Member's care.
  - A contracted Provider assumes responsibility for the Member's care through transfer to another place of service.
  - A Molina representative and the treating physician reach an agreement concerning the Member's care.
  - The Member is discharged.

Emergency Ancillary Services Provided at a Hospital

Emergency ancillary services that are provided in a hospital include, but are not limited to, radiology, laboratory, emergency medicine, and anesthesiology. Molina will reimburse emergency ancillary services rendered by non-contracted Providers in a hospital setting at the published Nebraska Medicaid fee schedule in effect on the Date of Service.

Hospice Services

Hospice services are covered when they are ordered by a physician and performed by a Medicare-certified hospice provider enrolled as a Medicaid provider. Hospice services require prior authorization. Hospice services focus on supportive care, comfort, and quality of life for those Members in the final phase of a terminal illness. Molina's Care Management team will review a Member's Individualized Care Plan (ICP), which includes a Member's desire for hospice services, palliative care and support to determine authorization.

Home Health

Home Health services are covered when they are ordered by a physician or practitioner and performed by a Medicare certified Home Health agency, that is enrolled as a Medicaid provider on a full-time, part-time or intermittent basis to a Member in a place of temporary or permanent residence as in the Member's home. Home health services require prior authorization after six (6) initial visits, requiring a signed Plan of Care (POC) to be submitted to obtain prior authorization.

Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, 365 days a year, to assess symptoms and help make good health care decisions.

Molina is committed to helping our Members:

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

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

Telehealth and Telemedicine Services

Molina Members may obtain physical and behavioral health Covered Services by Participating Providers, using telehealth and telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a Participating Provider.
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth. Reimbursement will be at the in-person clinic rate. Clinic-originating sites may be reimbursed a facility fee.
- Services are a method of accessing Covered Services, not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Member cost sharing may apply based on the applicable benefit guide found in the Member Handbook.
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Provider must comply with applicable Federal and State guidelines for telehealth service delivery.

For Telemedicine Services, the following documentation in the Provider's medical records must contain support for:

- Medical necessity for telemonitoring.
- All transmitted data.
- Health care Provider review of the transmitted data.
- Application of the transmitted data for continuous development and implementation of the Member's plan of care.
- The Member is cognitively capable of operating the equipment or has a willing and able person to assist in the transmission of the electronic data.
- The originating site has space for all program equipment and full transmission capability.

For additional information on telehealth and telemedicine claims and billing, please refer to the Claims and Compensation Billing Guide.

HEALTH CARE SERVICES

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, Medical Necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)

Molina ensures the service delivered is Medically Necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care, as well as integrating a range of services appropriate to meet individual needs. Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence the Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring qualified health care professionals perform all components of the UM processes.
- Ensuring that UM decision-making tools are appropriately applied in determining Medical Necessity decisions.

Key Functions of the UM Program

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

- **Eligibility and Oversight**
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to Member's Medical Necessity need(s) and benefit plan
  - Verifying of current Physician/hospital contract status
- **Resource Management**
  - Prior authorization and referral management
  - Pre-admission, admission, and inpatient concurrent review
  - Referrals for discharge planning and care transitions
  - Staff education on consistent application of UM functions
- **Quality Management**
  - Satisfaction survey analysis of the UM program using Member and Provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - Quality oversight
  - Monitor for adherence to CMS, NCQA, State and health plan UM standards

For more information about Molina's UM program, or to obtain a copy of the HCS Program Description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina website at MolinaHealthcare.com or contact the UM department at (844) 782-2678.

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

UM Decisions

A decision is any determination made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide, or pay for services (favorable determination).
- Determination to delay, modify, or deny authorization or payment of request (adverse determination).
- Discontinuation of a payment or authorization for a service.

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

Board certified licensed Providers from appropriate specialty areas are utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA standards.

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician, pharmacist, doctoral-level clinical psychologist, or certified addiction medicine specialist as appropriate may determine to delay, modify, or deny authorization of services to a member.

Providers can contact Molina's Healthcare Services department at (844) 782-2678 to obtain Molina's UM Criteria.

Where applicable, Molina Corporate Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical Necessity

"**Medically Necessary**" or "**Medical Necessity**" means health care services and supplies that are medically appropriate and:

- Necessary to meet the basic health needs of the Member.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service.
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies.
- Consistent with the diagnosis of the condition.
- Required for means other than the convenience of the client or their physician.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.
- Of demonstrated value.
- No more intensive level of service than can be safely provided.

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

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

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

The fact that a Provider has prescribed, recommended, or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for the delivery of care:

- Transparency—Delivers medical determination transparency.
- Access—Clinical evidence that payers use to support Member care decisions.
- Security—Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking prior authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina has also partnered with MCG Health to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/seven days per week. This method of submission is strongly encouraged as your primary submission route. Existing fax/phone/email processes will also be available. Clinical information submitted with the prior authorization will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each prior authorization request and sending it directly to Molina, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs and PET scans. To see the full list of imaging codes that require prior authorization, refer to the prior authorization code LookUp Tool at MolinaHealthcare.com.

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review,

or retrospectively. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence-based guidelines, third-party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Molina review process begins with an administrative review followed by a clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. The Clinical review includes Medical Necessity and level of care.

All UM requests that may lead to a Medical Necessity adverse determination are reviewed by a health care professional at Molina (medical director, pharmacist, or appropriately licensed health professional).

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

Clinical Information

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

Prior Authorization

Molina requires prior authorization for specified services if it complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com.

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

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and ICD-10 codes.

- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the Medical Necessity of the requested service is required including:
  - Pertinent medical history (including treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and Member eligibility at the time of service. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the Date of Service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require prior authorization.

Molina follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborn Mothers Health Protection Act.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determinations/pre-service authorization request, Molina will make a determination as promptly as the Member's health requires and no later than contractual and regulatory requirements after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provides notification no later than contractual requirements.

Request Type	Notification Timeframe
Prior Authorization **Standard**	14 Calendar days
Prior Authorization **Urgent**	72 hours

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 (844) 782-2678.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the Provider via fax.

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five (5) business days of the denial notification.

A "peer" is considered a physician, physician assistant, or nurse practitioner who is directly providing care to a Molina member and can request a peer-to-peer telephone communication with a Molina Medical Director.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID number.
- Auth ID number.
- Requesting Provider name and contact number and best times to call.

You may schedule a peer-to-peer conversation with a Molina medical director on the Provider website located at MolinaHealthcare.com. On the Provider website, click the P2P scheduling button and populate the required information. Please provide two (2) to three (3) available times that the Provider is available for a peer-to-peer consultation. Our scheduler will call to confirm the peer-to-peer appointment. For advanced imaging, behavioral health or pharmacy peer-to-peer scheduling, please follow the instructions listed in your denial letter.

Requesting Prior Authorization

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

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

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

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com.

Availity Essentials portal: Participating Providers are encouraged to use the Availity Essentials portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal.

Managing prior authorizations/service requests electronically provides many benefits to Providers, such as:

- Easy to access
- 24/7 online prior authorization submission
- Ensures HIPAA compliance
- Upload medical records required for timely medical review and decision making
- Receive real-time authorization status
- Receive notification of change in status of Authorization Requests.
- Increased efficiency through reduced telephonic interactions
- Reduced cost associated with fax and telephonic interactions

Molina offers the following electronic prior authorizations/service requests submission options:

- Submit requests directly to Molina via the Availity Essentials Portal.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance.

Fax: The Prior Authorization Request Form can be faxed to Molina at (833) 832-1015.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at (844) 782-2678. It may be necessary to submit additional documentation before the authorization can be processed.

Open Communication about Treatment

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

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

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

During business hours, HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (844) 782-2678 during normal business hours, Monday through Friday (except for holidays) from 8 a.m. to 5 p.m. All staff members identify themselves by providing their first name, job title, and organization.

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

After business hours, Providers can also utilize fax and the Availity Essentials portal for UM access.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (844) 782-2721. Molina's Nurse Advice Line handles post-stabilization, urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Emergency Services

Emergency Services means covered inpatient and outpatient services that are either furnished by a Provider that is qualified to furnish these services under Title 42 CFR, or the services needed to evaluate or stabilize an Emergency Medical Condition.

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

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- See 42 CFR § 438.114(a).

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the Member does not require prior authorization from Molina.

Emergency Services are covered on a twenty-four (24)-hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition and are reimbursed at 100% of the current Medicaid FFS rate on the date of service.

Molina also provides Members with a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

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

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

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

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective procedures at any facility. Facilities are required to also notify Molina within twenty-four (24) hours or by the following business day once admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, Medical Necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not Covered Services, unless Law or Government Program requirements mandate otherwise.

Inpatient/Concurrent Review

Molina performs concurrent inpatient reviews to ensure the Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular

intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission, dependent on the Provider contract terms and agreements.

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

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding, and Medical Necessity requirements (refer to the Medical Necessity subsection of this Provider Manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

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

Readmissions

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

Molina will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

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

When a subsequent admission to the same facility occurs within 2-30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
  - Premature or inadequate discharge from the same hospital.
  - Issues with transition or coordination of care from the initial admission.
  - For an acute medical complication plausibly related to care that occurred during the initial admission.
- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple traumas, and burns.
  - Neonatal and obstetrical readmissions.
  - Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
  - Behavioral Health readmissions.
  - Transplant-related readmissions.

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of the post-service review is if information is received within ten (10) business days indicating the Provider did not know nor reasonably could have known that the patient was a Molina Member or there was a Molina error, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence-based criteria sets.

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

Affirmative Statement about Incentives

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

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

Out-of-Network Providers and Services

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

Emergency medical services, post stabilization services and emergency ancillary services are reimbursed at 100% of the current Medicaid FFS rate on the date of service. Emergency ancillary services are defined as those services provided in a hospital, including but not limited to, radiology, laboratory, emergency medicine, and anesthesiology due to an emergent episode.

All out of network services except in the case of emergency, family planning or Indian Health protected services require prior authorization. Reimbursement to out-of-network providers, except when required by law or policy, will be reimbursed at 90% of the current Medicaid FFS rate. Please see the Molina Nebraska Out-of-Network Policy available on our website.

Avoiding Conflict of Interest

The HCS department affirms its decision-making is based on the appropriateness of care and service and the existence of benefit coverage.

Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision makers to make determinations that result in underutilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

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

Molina staff provide an integrated approach to care needs by assisting Members with the identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, and identifying best practices or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with

Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

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

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

For additional information regarding continuity of care and transition of Members, please contact Molina at (844) 782-2678.

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, Dental Homes and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of Suspected Abuse and/or Neglect

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

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

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or child care givers.

- Psychologists, social workers, family protection workers or specialists.
- Attorneys, ministers, or law enforcement officers.

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

Child Abuse

Report suspected abuse or neglect to the Child Abuse and Neglect Hotline at (800) 652-1999.

For additional information, reach out to DHHS at DHHS.ChildrenandFamilyServices@nebraska.gov.

Adult Abuse

Adult Protective Services (APS) meets the needs of vulnerable adults and helps protect them from abuse, neglect, and exploitation.

Report suspected abuse or neglect of a vulnerable adult to Adult Protective Services at (800) 652-1999.

Molina's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

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

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 the Member's Individualized Care Plan (ICP), interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and the primary medical care of Members.

Case Manager Responsibilities

The case manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from the Member's ICT as applicable. ICP interventions include the appropriate information to address medical and

psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the case manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the case manager:

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

Disease Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level 1 Members can be engaged in the program for up to sixty (60) days, depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Low Risk – Disease Management

Molina offers care management to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition-specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings. Members can request to be enrolled or dis-enrolled in these programs at anytime. Our Molina My Health programs include:

- Molina My Health – Asthma
- Molina My Health – Bipolar Disease
- Molina My Health – Coronary artery disease (CAD
- Molina My Health – Congestive heart failure (CHF)
- Molina My Health – Chronic obstructive pulmonary disease (COPD)
- Molina My Health – Diabetes
- Molina My Health – HIV/AIDS
- Molina My Health – Hypertension
- Molina My Health – Major depressive disorder (MDD)
- Molina My Health – Schizophrenia
- Molina My Health – Substance use disorder (SUD)

For more information about these programs, please call (866) 891-2320 (TTY/TDD at 711 Relay).

Maternity Screening and High-Risk Obstetrics

Molina offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high-risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for Members with identified high-risk pregnancies to ensure best outcomes for Members and their newborns during pregnancy, delivery and through their sixth-week post-delivery. Pregnant Member outreach, screening, education, and care management are initiated by Provider notification to Molina, Member self-referral and internal Molina notification processes. Providers can notify Molina of pregnant/ high-risk pregnant Members via faxed Pregnancy Notification Report Forms.

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. The form should be faxed to Molina at (833) 352-2359.

Member Newsletters

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

Member Health Education Materials

Members can access our easy-to-read, evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Molina mobile App.

Program Eligibility Criteria and Referral Source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

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

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims with a relevant CMS-accepted diagnosis or procedure code.

- Member Services welcome calls made by staff to new Member households, and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry.
- Member assessment calls made by staff for the initial health risk assessments (HRA) for newly enrolled Members.
- External referrals from Provider(s), caregivers or community-based organizations.
- Internal referrals from Nurse Advice Line Medication Management or Utilization Management.
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications.

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider newsletters promoting the Health Management programs, including how to enroll patients and outcomes of the programs.
- Clinical practice guidelines.
- Preventive health guidelines.
- Case Management collaboration with the Member's Provider.
- Faxing a Provider Collaboration Form to the Member's Provider when indicated.

Additional information on Health Management programs is available from your local Molina Healthcare Services department.

Primary Care Providers

Molina provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina. Molina's Members are required to see a PCP who is part of the Molina Network. Molina's Members may select or change their PCP by contacting Molina's Member Services.

Specialty Providers

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women's health specialists for routine and preventive health without a referral for services.

Molina will help to arrange specialty care outside the network when Providers are unavailable, or the network is inadequate to meet a Member's medical needs. To obtain such assistance

contact the Molina UM department at (844) 782-2678. Referrals to specialty care outside the network require prior authorization from Molina.

Case Management (CM)

Level II Case Management and Level III Complex Case Management

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

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

Referral to Case Management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the CM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, such as discharge planners, ancillary Providers, the local Health Department, or other community-based resources when identified. The referral source should be prepared to provide the care 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 CM Program for evaluation:

- High-risk pregnancy for Members, including a history of a previous preterm delivery prior to thirty-seven (37) weeks or an adverse pregnancy outcome.
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End-Stage Renal Disease).
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.).
- Preterm births.
- High-technology home care requiring more than two (2) weeks of treatment.
- Member accessing emergency department services inappropriately.
- Children with Special Health Care Needs

- A disabling mental disorder
- A chronic substance abuse disorder.
- A physical, intellectual, or developmental disability with functional impairment that significantly impairs the individual from performing one or more activities of daily living each time the activity occurs; see 471 NAC § 12 for the definition of activities of daily living for adults.
- A disability determination based on Social Security criteria.
- A serious and complex medical condition.
- Chronically homeless.
- Foster care children and adolescents aging out of the foster care system.
- Dual eligible.
- Transitioning from a state facility to the community.
- Special needs adolescents aging out who will no longer be eligible for EPSDT services.

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

Phone: (844) 782-2678
Fax: (833) 352-2359
Email: NE_CM@MolinaHealthcare.com

BEHAVIORAL HEALTH

Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Some Behavioral Health services may require prior authorization.

Emergency psychiatric services do not require prior authorization. All requests for Behavioral Health services should include the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted Medical Necessity criteria for prior authorization reviews.

Providers requesting authorization for inpatient Behavioral Health services should utilize the Availity Essentials portal, submit via fax at (833) 832-1015, or contact Molina's prior authorization team at (844) 782-2678.

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

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

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com.

For additional information, please refer to the Prior Authorization subsection found in the Health Care Services section of this Provider Manual.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network Behavioral Health Provider via referral from a PCP or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected Behavioral Health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. A formal referral form or prior authorization is not needed for a Member to self-refer or be referred to a PCP or Behavioral Health Provider.

Behavioral Health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to a PCP and specialty care Provider to manage their health care needs. Behavioral Health Providers may identify other health concerns, including physical health concerns, which should be addressed by referring the Member to a PCP.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge and to occur within seven (7) days of discharge.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase the communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Case Management

Molina's Case Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a Behavioral Health or Primary Care Provider to the CM program.

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

Phone: (844) 782-2678
Fax: (833) 352-2359
Email: NE_CM@MolinaHealthcare.com

Additional information on the CM program can be found in the Case Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of both physical and behavioral health services in an effort to provide quality care coordination to Members. Behavioral Health Providers are expected to provide in-scope, evidence-based mental health and substance use

disorder services to Molina Members. Behavioral Health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality standards related to access. Molina provides oversight of Providers to ensure Members can obtain needed health services within the acceptable appointment timeframes. Please see the Quality section for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven (7) days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within twenty-four (24) hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24 hours a day, seven days a week, 365 days a year. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services telephone number on the back of their Molina ID Card: (844) 782-2018.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else) can receive free and confidential support 24 hours a day, seven days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, training opportunities for providers, and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both primary care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the MolinaHealthcare.com Provider website.

QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality department at (844) 782-2678, Monday – Friday, 7 a.m. – 6 p.m. Central Time, except for state holidays.

The address for mail requests is:

Molina Healthcare of Nebraska, Inc.
Attn: Quality Department
14748 W. Center Rd. Suite 140
Omaha, NE 68144

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

Molina has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

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

- Have a Quality Improvement Program in place.
- Comply with and participate in Molina's Quality Improvement Program, including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve the quality of care and services and Member experience.
- Allow Molina to collect, use, and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina Quality personnel for site and medical record review processes.
- NOTE: Molina does not pay for medical record copies for investigation of quality-of-care concerns or for other quality or utilization review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management, care management/disease management programs and education.

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

Quality of Care

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

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

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

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed, and organized to ensure that care rendered to Members is consistently documented (hard copy or electronic) and that necessary information is readily available in the medical record in accordance with Molina Healthcare of Nebraska's policies and procedures. All entries will be indelibly added to the Member's record. A Member's medical record is the property of the Provider who generates the record. PCPs should maintain the following medical record components that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records.
    - Each Member is entitled to a copy of their medical record at no cost.
    - Upon notification of a Member transferring providers, Molina Healthcare of Nebraska will ensure their medical records or copies of medical records are forwarded to the new PCP within ten (10) business days from receipt of the request for transfer of the medical records.

- MLTC is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency.
  - Molina Healthcare of Nebraska must afford MLTC access to all members' medical records, whether electronic or paper, within 20 business days of receipt of the request or more quickly if necessary, in MLTC's sole determination.
- Medical record content and documentation standards include legibility, accuracy, and plan of care that comply with applicable law and Molina Healthcare of Nebraska written standards.
- Storage maintenance and disposal processes.
- Process for archiving medical records and implementing improvement activities.
- If care has not been established, information may be kept temporarily in an appropriately labeled file in lieu of a permanent medical record. The temporary file must be associated with the Member's medical record as soon as one is established.
- Information related to fraud and abuse may be released. However, HIV-related information may not be disclosed except as provided in state statute, and substance use disorder information shall only be disclosed consistent with federal and state law, including, but not limited to 42 CFR § 2.1 et seq.

Medical Record Keeping Practices

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

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

Content

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

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, gender, legal guardianship (if applicable), marital status, address, employer, home and work telephone numbers, and emergency contact.

- Primary language spoken by the member and any translation needs.
- Legible signatures and credentials of the Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
    - Documentation of each visit must include the date, begin and end times of service, location of service, chief complaint or purpose of visit, diagnoses or medical impression, objective findings, patient assessment findings, studies ordered and results of those studies (e.g., laboratory, x-ray, EKG, etc.) medications prescribed, health education provided.
- Notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants if applicable.
- Treatment plans that are consistent with the diagnosis.
- Signed and dated consent forms (as applicable)
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals /outcomes of referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within thirty (30) days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of advance directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials and credentials.
- All abnormal lab/imaging results show explicit follow-up plan(s).
- All ancillary services reports.
- Documentation of all emergency care or after-hours encounters and follow-up provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report.
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.
- Documentation of EPSDT requirements including but not limited to comprehensive health history, developmental history, unclothed physical exam, vision, hearing, and dental screening, immunizations, lab testing including mandatory lead screening, and health education and anticipatory guidance.

Organization

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

Retrieval

- The medical record is available to the Provider at each encounter.
- The medical record is available to Molina for purposes of Quality Improvement.
- The medical record is available to the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request at no cost.
- A storage system for inactive Member medical records that allows retrieval within twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than ten (10) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

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

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA, please refer to the Compliance section of this Provider Manual.

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directive requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance directives are a written choice for health care. There are two (2) types of advance directives:

- **Durable Power of Attorney for Health Care** allows an agent to be appointed to carry out health care decisions.
- **Living Will** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

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

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

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

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

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

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS Law gives Members the right to file a complaint with Molina or the State survey and certification agency if the Member is dissatisfied with Molina's handling of advance directives and/or if a Provider fails to comply with advance directives instructions.

Molina will notify the Provider via fax of an individual Member's advance directives identified via Healthcare Services programs. Providers are instructed to document the presence of an advance directive in a prominent location of the Medical Record. Auditors will also look for

copies of the advance directive form. Advance Directives forms are State-specific to meet State regulations.

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

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine, and pediatrics), OB/GYN (high-volume specialists), Oncologist (high-impact specialists), and behavioral health Providers. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available to Members 24 hours a day, seven days a week.

Appointment Access

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

Medical Appointment

Appointment Types	Standard
Non-urgent preventive	Within 4 weeks
Non-urgent, sick	Within 48 hours, or sooner if condition becomes urgent
Urgent Care	Same day, provided by PCP or as arranged by Molina
Maternity Care	• First Trimester: Within 14 calendar days • Second Trimester: within 7 calendar days • Third Trimester and High-Risk: Within 3 calendar days • Emergency: Immediately
Family Planning	Within 7 calendar days
Laboratory and X-Ray	Within 3 weeks for routine and 24 hours for urgent or as clinically indicated.
After Hours Care	24 hours/day; 7 day/week availability
Specialty Care (High Volume)	Within 30 calendar days
Specialty Care (High Impact)	Consultation within 1 month of referral or as clinically indicated
Urgent Specialty Care	Within 24 hours

Appointment Types	Standard
Emergency Services	Immediately upon presentation, 24 hours a day, 7 days per week.

Behavioral Health Appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately
Urgent Care	Within 48 hours
Initial Routine Care Visit	Within 10 business days
Follow-up Routine Care Visit	Within 30 calendar days
BH Emergency Services	Referral within 1 hour (2 hours in designated rural areas)

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

Dental Appointment

Appointment Types	Standard
Urgent Care	Within 24 hours
Routine or Preventive Care Visit	Within 6 weeks

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed forty-five (45) minutes. All PCPs and dental Providers are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have backup (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, seven days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after hours is not acceptable.

Geographic Access Standards

Geographic Access Type	Standard
Contracted PCPs	• Urban: 2 PCPs within 30 miles of Members

Geographic Access Type	Standard
	• Rural: 1 PCP within 45 miles of Members • Frontier: 1 PCP within 60 miles of Members
High-volume specialists (cardiology, neurology, hematology/oncology, OB/GYN, and orthopedics)	1 high-volume specialty within 90 miles of Members
Pharmacy	• Urban: retail pharmacy within 5 miles of 90% of Members • Rural: retail pharmacy within 15 miles of 70% of Members • Frontier: retail pharmacy within 60 miles of 70% of Members
BH and Residential Service Providers	For rural and frontier Members able to travel and return home within 1 day (480 miles round trip)
BH Outpatient and Assessment Providers	• Urban: 2 Providers within 30 miles of Members • Rural: 2 Providers within 45 miles of Members • Frontier: 2 Providers within 60 miles of Members
BH Emergency Services	Referral within 1 hour (2 hours in designated rural areas)
Hospitals	Transport time within 30 minutes in Urban areas and within community standards for Rural and Frontier areas
Dental—General Dentist	• Urban: 2 general dentists within 45 miles of Members • Rural: 1 general dentist within 60 miles of Members • Frontier: 1 general dentist within 100 miles of Members
Dental—Dental Specialists (oral surgeon, orthodontist, periodontist, endodontist)	• Urban: 1 of each specialty within 45 miles of 85% of Members • Rural: 1 of each specialty within 60 miles of 75% of Members • Frontier: 1 of each specialty within 100 miles of 75% of Members

Women's Health Access

Molina allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Molina follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborn Mothers Health Protection Act (NMHPA). Molina also ensures providers and/or OBGYNs counsel pregnant members about plans for their newborn child on selecting a PCP for newborn exams and subsequent pediatric care once the child is covered under Molina. Additional information on access to care is available from your local Molina Quality department.

Monitoring Access for Compliance with Standards

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

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

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

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

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record-keeping practices standards. Molina continually monitors Member appeals and complaints/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against

standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

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

Physical Accessibility

Molina evaluates office sites as applicable to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space

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

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour, and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) 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, contracts, and evidence of a hazardous waste management system in place.

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

EPSDT Services to Enrollees Under 21 Years of Age

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

Well Child/Adolescent Visits

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

- Comprehensive health and developmental history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive, unclothed physical examination
- Appropriate immunizations according to the Advisory Committee on Immunization Practices
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors
- Periodic developmental and behavioral screening using a recognized standardized developmental screening tool
- Vision and hearing tests
- Dental assessment and services
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident, and disease prevention

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

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

Monitoring for Compliance with Standards

Molina monitors compliance with the established performance standards as outlined above at least annually. Performance below Molina's standards may result in a Corrective Action Plan (CAP) with a request the Provider submit a written corrective action plan to Molina within 30 calendar days. Molina will follow up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to the 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.

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism

- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and members by the Quality, Provider Services, Health Education and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider Bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from your local Molina Quality department.

Preventive Health Guidelines

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

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina's website)
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina's website)
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention. Links to current recommendations are included on Molina's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States. These recommendations are revised every year by the Centers for Disease

Control and Prevention. Links to current recommendations are included on Molina's website.

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

Measurement of Clinical and Service Quality

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

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

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

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following:

- Development of Quality Improvement activities
- Public reporting to consumers
- Preferred status designation in the network
- Reduced Member cost sharing

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

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects, including immunizations, women's health

screening, diabetes care, well check-ups, medication use, dental services, and cardiovascular disease.

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

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

Behavioral Health Satisfaction Assessment

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

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

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

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

What Can Providers Do?

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

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

RISK ADJUSTMENT PROGRAM

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) adjusts Health Plan payment amounts based on the overall health status and expected cost of enrolled beneficiaries. Risk Adjustment methodologies provide CMS the ability to accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive appropriate payment for members based on the severity of their health conditions. Risk Adjustment reduces any incentives for health plans to target healthier-than-average enrollment beneficiaries.

Why is Risk Adjustment Important?

Our Risk Adjustment program seeks to ensure encounter data is complete and accurate to appropriately represent our members' health acuity. Molina relies on our Provider Network to take care of our Members based on their health care needs. Documentation of clinical diagnoses allows us to:

- Focus on quality, gaps in care, and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for Case Management referral.
- Ensure adequate resources for the acuity levels of Molina Members.
- Have the resources to deliver the highest quality of care to Molina Members.

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by the Provider's electronic medical records (EMR), including, but not limited to, Direct Protocol, Secure File Transfer Protocol (sFTP), query or web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act

(HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have a direct address, the Provider will work with its EMR vendor to set up a direct account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having the Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with Molina's established interoperability partner to get an account established.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina for risk adjustment is complete and accurate. All Claims/Encounters submitted to Molina are subject to State and/or Federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Your Role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the appropriate highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and our Members.

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

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the Member.
- Be compliant with the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with the Member. The visit may be face-to-face or telehealth, depending on State or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and Date of Service.
- Have the Provider's signature and credentials.

Contact Information

For questions about Molina's Risk Adjustment programs, please contact your Molina Provider Services representative.

COMPLIANCE

Fraud, Waste, and Abuse

Introduction

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

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

Mission Statement

Our mission is to pay Claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care costs and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

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

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

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

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false

statements, falsifying records, double billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

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

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

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

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

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

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

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

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute (AKS) is a criminal Law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks — those who offer or pay

remuneration — as well as the recipients of kickbacks — those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKS) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc.

Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under Molina's policies, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly or indirectly, make or offer items of value to any third party for the purpose of obtaining, retaining, or directing our business. This includes giving favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under Molina's policies, marketing means any communication, to a beneficiary who is not enrolled with Molina, which can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state to state but generally relate to the types and forms of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception

applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark Law prohibits the submission, or causing the submission, of Claims in violation of the Law's restrictions on referrals. “Designated health services” are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

Sarbanes-Oxley Act of 2002

Sarbanes-Oxley Act of 2022 requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

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

Abuse means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to State and Federal health care programs, 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 costs to State and Federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste, and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider’s usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.

- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization.
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive,

or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

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

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

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

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

Post-payment Recovery Activities

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

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

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

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

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

Claim Auditing

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

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

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

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

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

Provider Education

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

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

Reporting Fraud, Waste, and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine telephone and web-based reporting is available 24 hours a day, seven days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached toll-free at (866) 606-3889, or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com.

You may also report cases of fraud, waste, or abuse to Molina's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Nebraska, Inc.
Attn: Compliance
200 Oceangate Blvd. Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entities involved in suspected fraud and/or abuse, including address, phone number, Molina Member ID number and any other identifying information.

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

Suspected Fraud by Medicaid Recipients:

Nebraska Department of Health and Human Services

DHHS.InvestigationsSIU@nebraska.gov

By Phone: (402) 595-3789

Suspected fraud or abuse by a Provider:

ago.medicaid.fraud@nebraska.gov

Toll-free: (800) 727-6432

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

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

Telehealth/telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act (HITECH Act)

Applicable Laws

Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that

protects all health information in the United States; instead, there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to the privacy of health information, including, without limitation, the following:

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

- **State Medical Privacy Laws and Regulations**

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

Uses and Disclosures of PHI

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

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

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

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

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

Confidentiality of Substance Use Disorder Patient Records

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

Inadvertent Disclosures of PHI

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

Written Authorizations

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

Patient Rights

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

- **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.

- **Requests for Restrictions on Uses and Disclosures of PHI**

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

- **Requests for Confidential Communications**

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

- **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.

- **Request to Amend PHI**

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

- **Request Accounting of PHI Disclosures**

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

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

Molina is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

- Click on the area titled "Healthcare Professionals"
- Click the tab titled "HIPAA"
- Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

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

Business Continuity Plan (BCP)

The Provider will have a documented Business Continuity Plan (BCP) to ensure the continuation and recovery of services after a disruption occurs. The BCP will be updated at least annually and approved by the applicable designated representative.

The Provider Business Continuity Plan will include:

- Names and contact information for staff responsible for invoking and managing response and recovery.
- Molina notification names and contact information.
- Disaster declaration process.
- Details of how the services will be recovered and restored.
- Details of how the systems and applications supporting the services will be recovered and restored, including recovery of data.

The Provider will notify Molina of a disruption to the services or activation of business continuity plans within two (2) hours of occurrence and will provide Molina with regular updates on the situation and actions taken to resolve the issue until normal services have been resumed.

The Provider will ensure that its third parties needed to deliver the services have appropriate Business Continuity Plans in place to prevent significant disruption to the services.

The Provider will test the BCP at least annually and document the test results. Provider will make available to Molina, upon request, the results of the most recent test including lessons learned and remediation plans.

The Provider will participate in Molina annual tests upon notification and mutual agreement.

After disruption to services, once normal service has been resumed, the Provider will promptly complete a root cause analysis report and provide it to Molina.

Definitions

Business Continuity Plan: documented procedures that guide organizations to respond, recover, resume, and restore to a pre-defined level of operations following a disruption.

Disaster Recovery Plan: a document that defines the resources, actions, tasks, and data required to manage the technology recovery effort.

Disaster Declaration: criteria to declare a disaster and the staff authorized to invoke recovery plans to recover and restore services.

Cybersecurity Requirements

Note: This section (Cybersecurity Requirements) is only applicable to Providers who are delegated Providers and have been delegated by Molina to perform a health plan function.

Provider shall comply with the following requirements and permit Molina to audit such compliance as required by Law or any enforcement agency.

The following terms are defined as follows:

- "Consumer" means an individual who is a State resident, whose Nonpublic Information is in Molina's possession, custody or control and which Provider maintains, processes, stores or otherwise has access to such Nonpublic Information.
- "Cybersecurity Event" means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or misuse an Information System or Nonpublic Information stored on such Information System. The ongoing existence and occurrence of attempted but Unsuccessful Security Incidents shall not constitute a Cybersecurity Event under this definition. "Unsuccessful Security Incidents" are activities such as pings and other broadcast attacks on the Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Molina Nonpublic Information or sustained interruption of service obligations to Molina.
- "Information System" or "Information Systems" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic Nonpublic Information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.
- "Nonpublic Information" means information that is not publicly available information and is one of the following:

- Business-related information of Molina, the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina.
- Any information concerning a Consumer that, because of the name, number, personal mark, or other identifier contained in the information, can be used to identify such Consumer, in combination with any one or more of the following data elements:
    - Social Security number.
    - Driver's license number, commercial driver's license, or state identification card number.
    - Account number, credit, or debit card number.
    - Security code, access code, or password that would permit access to a Consumer's financial account.
    - Biometric records.
- Any information or data, except age or gender, in any form or medium created by or derived from a health care Provider or a consumer that can be used to identify a particular consumer and that relates to any of the following:
    - The past, present, or future physical, mental, or behavioral health or condition of a consumer or a member of the consumer's family.
    - The provision of health care to a consumer.
    - Payment for the provision of health care to a consumer.
    - "State" means the State of Nebraska.

Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information, as defined herein, that are accessible to, or held by, the Provider. Implementation of the foregoing measures shall incorporate guidance issued by the State Department of Insurance, as appropriate.

- Provider agrees to comply with all applicable Laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities, except where the Provider is solely responsible and required to notify such Consumers or government entities by Law. Upon Molina's prior written request, the Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable Law.
- In the event of a Cybersecurity Event, the Provider shall notify Molina's Chief Information Security Officer of such Cybersecurity Event by telephone and email (as provided below) as promptly as possible, but in no event later than twenty-four (24) hours from a determination that a Cybersecurity Event has occurred. In addition to the foregoing, the Provider shall notify Molina's Chief Information Security Officer (by telephone and email) within twenty-four (24) hours following payment of a ransom that involves or may involve Molina Nonpublic Information.

Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer

Telephone: (844) 821-1942
Email: CyberIncidentReporting@MolinaHealthcare.com

A follow-up notification shall be provided by mail at the address indicated below:

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

Upon Provider's notification to Molina of a determination of a Cybersecurity Event, the Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, the Provider shall complete an investigation pursuant to the following requirements:

- Determine whether a Cybersecurity Event occurred.
- Assess the nature and scope of the Cybersecurity Event.
- Identify Nonpublic Information that may have been involved in the Cybersecurity Event.
- Perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of the Nonpublic Information.

Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable Laws and produce those records upon request of Molina.

Provider must provide to Molina the following information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina in the initial and subsequent notices must include as much of the following information known to the Provider at the time of the notification:

- The date of the Cybersecurity Event.
- A description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of the Provider, if any.
- How the Cybersecurity Event was discovered.
- Whether any lost, stolen, or breached information has been recovered and, if so, how this was done.
- The identity of the source of the Cybersecurity Event.
- Whether the Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided.
- A description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information,

types of financial information, or types of information allowing identification of the Consumer.
- The period during which the Information System was compromised by the Cybersecurity Event.
- The number of total Consumers in the State affected by the Cybersecurity Event.
- The results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed.
- A description of efforts being undertaken to remediate the situation that permitted the Cybersecurity Event to occur.
- A copy of Provider's privacy policy and, if requested by Molina, the steps that Provider will take to notify Consumers affected by the Cybersecurity Event.
- The name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of the Provider.
- Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments.
- Provider shall ensure that all workforce members are provided regular Cybersecurity awareness and training.

In the event provisions of this Section conflict with provisions of any other agreement between Molina and the Provider, the stricter of the conflicting provisions will control.

CLAIMS AND COMPENSATION

Payor ID	**MLNNE**
Availity Essentials portal	**Provider.MolinaHealthcare.com**
Clean Claim Timely filling	**180 calendar days from the discharge for inpatient services or the Date of Service for outpatient services**

Electronic Claims Submission

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

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity Essentials portal.
- Submit Claims to Molina via your regular EDI clearinghouse.

Availity Essentials Portal

The Availity Essentials portal is a no-cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files.
- Correct/Void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and manage Claim Templates.
- Create and submit a Claim appeal with attached files.

Clearinghouse

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

If you do not have a clearinghouse, Molina offers additional electronic Claims submissions options, as shown by logging on to the Availity Essentials portal.

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 ensure that 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 a 277CA response file with the initial status of the Claims from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- 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 should contact their Provider Relations representative for additional support.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the 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 the coordination of benefits or third-party liability, the 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.

i. Molina will not deny Provider Claims on the basis of untimely filing for Claims that involve coordination of services or subrogation (when the Provider is pursuing payment from a third party). In situations of third-party benefits, the timeframes for filing a Claim must begin on the date that the third party completes the resolution of the Claim.
ii. Molina will not deny Claims solely for failure to meet timely filing guidelines due to an error by MLTC or its subcontractors. If a Provider files erroneously with another MCO but produces documentation verifying that the initial filing of the Claim occurred timely, Molina will process the Provider's Claim and not deny for failure to meet timely filing guidelines.

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 through a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA-compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims). 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.

Claims Recovery

Molina's Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Provider Overpayment Disputes	Molina Healthcare of Nebraska, Inc. PO Box 2470 Spokane, WA 99210-2470
Refund Checks Lockbox	Molina Healthcare of Nebraska, Inc. PO Box 604234 Charlotte, NC 28260 -4234
Phone:	(866) 642-8999
Fax:	(833) 970-3016
Availity Essentials Portal	Provider.MolinaHealthcare.com

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.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at EDI > Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of

the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan-specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Rendering Provider information when different than billing
- Billing/Pay-to-Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), the unit of measure and quantity for medical injectibles
- E-signature
- Service Facility Location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and applies to atypical and out-of-state Providers. **Provider information submitted on the Claim must match the information on file with the Nebraska Medicaid and Long-Term Care Division (MLTC) in order for Claim payment to be made**. Changes to Provider information should be made to MLTC's Maximus Provider Enrollment Platform prior to claim submission to Molina.

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

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission is required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error, and the Claim will be rejected.

Claim corrections submitted without the appropriate frequency code will be denied as a duplicate and the original Claim number will not be adjusted.

Paper Claim Submissions

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

Molina Healthcare of Nebraska, Inc.
PO Box 93218
Long Beach, CA 90809-9994

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box. Claims received outside of the designated PO Box will be returned for appropriate submission.

- Paper Claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either ten (10) or twelve (12) point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Molina strongly encourages Participating Providers to submit Corrected Claims electronically via EDI or the Availity Essentials portal.

All corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim or the applicable 837 transaction loop for submitting corrected Claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 180 calendar days of the Date of Service.

Corrected Claims submission options:

- Submit corrected Claims directly to Molina via the Availity Essentials portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

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

Third-party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

Medicaid is always the payer of last resort, with the exception of certain programs (i.e., Indian Health Services, Ryan White Program, World Trade Center Health Program and other federally designated programs), and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third-party liability can be established, Providers must first bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event that coordination of benefits occurs, the Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents.

Subrogation – Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under State and Federal Law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to Molina's vendor, Optum at submitreferrals@optum.com.

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented using 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. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burn
  - Other Injuries
- Manifestations of Poor Glycemic Control
  - Hypoglycemic Coma
  - Diabetic Ketoacidosis
  - Non-Ketotic Hyperosmolar Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity

- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
- Surgical Site Infection Following Certain Orthopedic Procedures:
  - Spine
  - Neck
  - Shoulder
  - Elbow

Surgical Site Infection Following Bariatric Surgery Procedures for Obesity

- Laparoscopic Gastric Restrictive Surgery
- Laparoscopic Gastric Bypass
- Gastroenterostomy

Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)

- Latrogenic Pneumothorax with Venous Catheterization
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
- Total Knee Replacement
- 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.
- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

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

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the MolinaHealthcare.com website under the "Policies" tab. Questions can be directed to your Provider Relations representative.

Additional Molina Healthcare of Nebraska Specified Payment Policies

Providers are reimbursed according to the reimbursement methodology and terms specified in the contract in addition to those described below. Reimbursement for Covered Services will be the lesser of the:

- Provider's submitted charge.
- Allowable amount for the service indicated on the applicable State of Nebraska Medicaid and Long-Term Care Fee Schedules per the Provider type in effect for the date service.
- Covered Service if the rate is not listed on the fee schedule, and it is described as a manually priced code. Molina Healthcare of Nebraska shall follow the pricing logic established by the State of Nebraska Medicaid and Long-Term Care for manually priced codes.

Manually Priced Codes

Manually priced codes are identified on the State of Nebraska Medicaid and Long-Term Care Fee Schedules with an indicator as follows:

- RNE – Rate Not Established
- BR – By Report
- IC – Invoice Cost
- IC + 30% - Invoice Cost plus 30%
- MP – Manually Priced

Manually priced codes follow the pricing methodology stated below in Table 1, unless noted with an asterisk as an exception and further described.

Table 1 – Manually Priced Codes

Manually Priced Code Descriptor	No Rate on Medicaid Fee Schedule, defaults to:	No Rate on Medicare Fee Schedule, defaults to:
RNE or BR	CMS Medicare Fee Schedule	% of Billed Charge*
IC	100% of Invoice Cost	N/A
IC + 30%	Invoice Cost + 30%	N/A
MP	CMS Medicare Fee Schedule	*

*CPT/HCPCS codes with a RNE, BR, or MP status without a rate on the CMS Medicare Fee Schedule shall pay as follows:

- Ambulance, Clinical Lab, Hearing Aid, Physician, Speech Pathology, Audiology and Vision Covered Services codes shall pay a percent of billed charges.
- Miscellaneous or unlisted codes (i.e. 45399, etc.) reimbursement will be based upon equal value of a like code.
- Durable Medical Equipment shall reimburse at 100% of invoice cost plus 30%.
- For injectable codes listed on the Injectable fee schedule as BR, RNE, or MP, the following payment hierarchy will be followed:
  - Pay using Medicaid rate.
  - If Medicaid rate is not listed, pay according to Medicare rates.
  - If Medicare rate is not listed, pay Wholesale Acquisition Cost (WAC) plus 6.8.
  - If WAC rate is not available, reimburse at 100% of invoice.
- Practitioner administered injectable medications, including specialty drugs, purchased through the 340B Program will be reimbursed at the 340B actual acquisition cost and no

more than the 340B ceiling price. Injectables listed on the Injectable fee schedule with a rate of "OP" are not payable on a practitioner claim but would be paid under the outpatient reimbursement methodology (i.e. EAPG, CAH).

Non-Covered Services

Molina Healthcare of Nebraska considers a non-covered service to mean a CPT/HCPCS code that is:

- Listed on the published fee schedule as Non-Covered, Obsolete, or Non-Covered by Medicaid or other similar language.
- A code not found on a published State of Nebraska Medicaid and Long-Term Care Fee Schedule.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM.
- For procedures:
  - Professional and outpatient Claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 (HCPCS codes).
  - Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System).

Furthermore, Molina requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

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

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCD).
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCD).

    - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and Medical Necessity.
- Payment policies published by Molina.

Telehealth Claims and Billing

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

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to the Guidance Document from DHHS located at dhhs.ne.gov/Medicaid%20Provider%20Bulletins/Provider%20Bulletin%2023-08.pdf.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Molina uses NCCI standard payment methodologies.

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

General Coding Requirements

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

CPT and HCPCS Codes

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

Modifiers

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

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

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

ICD-10-CM/PCS Codes

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

Place of Service (POS) Codes

Place of Service Codes (POS) are two (2)-digit codes placed on health care professional Claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual. Revenue Code 0510 is considered a non-covered service.

Diagnosis Related Group (DRG)

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

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

National Drug Code (NDC)

The National Drug Code number (NDC) must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04) or its electronic equivalent.

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

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition — an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used

primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three (3) types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

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

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

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

Claim Auditing

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

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

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

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

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

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 90% the Claims for service within fifteen (15) days and 99% of Claims for service within sixty (60) days after receipt of Clean Claims.

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

For pharmacy Providers, in accordance with 42 CFR § 447.45, Molina will establish, at a minimum, a weekly payment cycle so that a minimum of 90% of all Claims from pharmacy Providers for covered services are adjudicated within seven (7) calendar days of receipt and 99% of all Claims are adjudicated within fourteen (14) calendar days of receipt, except to the extent Providers have agreed to an alternative payment schedule set forth in the Provider contract. Any alternative payment schedules must be reported to MLTC within three (3) business days of our implementation.

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, provide 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 a retroactive review of the Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an Overpayment request letter if the Overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

- Submit a refund to satisfy Overpayment.
- Submit a request to offset from future Claim payments.
- Dispute Overpayment findings.

Instructions will be provided on the Overpayment notice, and Overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling, including the policy number, effective date, term date, and subscriber information. For Members with Commercial COB, Molina will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. For Members with Medicare COB, Molina will provide notice within 540 days from the Claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the Claim and pay or deny the Claim in accordance with Claim processing guidelines.

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 paid 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.

Overpayment Disputes should be received within thirty (30) days of the Overpayment notification letter. Overpayment Disputes should be sent to the address listed on the Overpayment notification. Overpayment Disputes can also be submitted via the Availity Essentials portal at Provider.MolinaHealthcare.com.

Claim Appeals/Disputes

Information on Provider Claim Appeals/Disputes is in the Complaints, Grievances, and Appeals Process section of this Provider Manual.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. As described in your Agreement with Molina Healthcare of Nebraska, balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

Fraud, Waste, and Abuse

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

Encounter Data

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

Encounter data must be submitted at least weekly and within thirty (30) days from the Date of Service to meet State and CMS encounter submission thresholds and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

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

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

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

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

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

COMPLAINTS, GRIEVANCES, AND APPEALS PROCESS

Member Grievance Process

A Grievance is a Member's expression of dissatisfaction with any matter other than an adverse benefit determination. Grievances may 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 regardless of whether remedial action is requested.

A Member or a Provider acting on behalf of a Member (with written consent) may file a grievance verbally or in writing anytime. Molina provides Members with reasonable assistance in completing forms and other procedural steps at no charge.

Grievance Timelines

Molina will acknowledge each grievance within ten (10) calendar days from the date Molina received the grievance. Molina will address each grievance, resolve, and provide notice as expeditiously as the Member's health condition requires, and under all circumstances within ninety (90) days from the date Molina received the grievance.

Member Appeals Process

Appeal means a review by Molina of an Adverse Benefit Determination.

Members or a Provider acting on behalf of a Member (with written consent) may file an appeal verbally or in writing. Appeals must be filed within sixty (60) calendar days from the date on the adverse benefit determination notice. Molina has only one level of Member appeals. Molina will acknowledge each appeal within ten (10) calendar days from the date Molina received the appeal.

Standard Appeals Process and Timeline

Molina will resolve appeals and provide notice as expeditiously as the Member's health condition requires, and within thirty (30) calendar days from the date Molina receives the appeal. Molina will provide written notice of the disposition of the appeal.

Molina may extend the timeframes by up to fourteen (14) calendar days if the Member request the extension or Molina shows that there is a need for additional information and the reason(s) why the delay is in the Member's interest.

Expedited Appeals Process and Timeline

Molina will resolve expedited appeals and provide notice as expeditiously as the Member's health condition requires, within seventy-two (72) hours after Molina receives the appeal. Molina will provide written notice of the disposition of the appeal.

Molina may extend the timeframes by up to five (5) calendar days if the Member requests the extension or the MCO shows that there is a need for additional information and the reason(s) why the delay is in the Member's interest. If the Plan denies a request for an expedited resolution of an appeal, it will transfer the appeal to the standard timeframe.

Appointment of Representative Process

Molina Members can file appeals and grievances on their own. They can also appoint someone else to file an appeal or grievance for them. This is called an "Authorized Representative." If a Provider is submitting an appeal or grievance on behalf of a Member, written consent from the Member is required. You can use Molina's Appointment of Representative (AOR) Form to complete this requirement.

Submission of Member Appeals and Grievances

Providers shall submit a Member appeal or grievance at:

- Fax: (833) 635-2044
- Mail: Molina Healthcare of Nebraska, Inc
  Appeals & Grievances Unit
  PO Box 182273
  Chattanooga, TN 37422
- Phone: (844) 782-2018

Continuation of Benefits During the Appeal or State Fair Hearing Process:

Molina will continue the Member's benefits while Molina's internal appeals process is pending and while the State Fair Hearing is pending if all the following conditions exist:

- The Member files the request for an appeal timely in accordance with 42 CFR § 438.402(c)(1)(ii) and (c)(2)(ii).
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized Provider.
- The period covered by the original authorization has not expired.
- The Member timely files for continuation of benefits. Timely files mean on or before the later of the following:
  - within ten (10) Calendar Days of the Plan mailing the Notice of Adverse Benefit Determination.
  - the intended effective date of the Plan's proposed Adverse Benefit Determination.

Molina will provide benefits until one of the following occurs:

- The Member withdraws the appeal or request for State Fair Hearing.
- The Member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after Molina send the notice of adverse resolution to the Member's appeal.
- The State Fair Hearing office issues a hearing decision not in the Member's favor.

To ask for continuation of benefits during the appeal process, the Member may call us or can send their request in writing to:

- Fax (833) 635-2044
- Mail: Molina Healthcare of Nebraska, Inc
  Appeals & Grievances Unit
  PO Box 182273
  Chattanooga, TN 37422

If the final appeal decision is not in the Member's favor, the Member may have to pay for the services they were getting while the appeal was being reviewed. If the final appeal decision is in the Member's favor and the services were not given to the Member while the appeal was being looked at, Molina will authorize the services for the Member as quickly as their health requires, but no later than seventy-two (72) hours from the date of the approval.

Molina will ensure that punitive action is not taken against any Provider who requests an expedited resolution or supports an appeal.

State Fair Hearing

A Member may request a State Fair Hearing if Molina's appeal system has been exhausted, and the final decision was not wholly in the Member's favor. The request for a State Fair Hearing must be submitted in writing within 120 calendar days from the date of Molina's resolution of the appeal.

Nebraska Department of Health and Human Services (DHHS)
MLTC Appeal Coordinator
PO Box 94967
Lincoln, NE 68509-4967

Provider Claim Appeal Request: A Provider Claim Appeal Request is not a Member appeal. Molina's Provider Claim Appeal process is detailed under the "Provider Complaints, Grievances, and Appeals, Process" heading.

Provider Claims Inquiry Process

A Provider Claims Inquiry is a Provider's initial request to adjust a claim that is **not related to a clinical decision.** Provider Claims Inquiries are accepted by phone within ninety (90) days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA).

To request a Provider Claims Inquiry, please call our Provider Services helpline at (844) 782-2678.

If you would like to (1) request adjustment of a claim that is related to a clinical decision, or (2) submit a formal request to adjust a claim, or (3) if you are dissatisfied with the outcome of your claim processing or initial claim adjustment, please use Molina's Provider Complaints, Grievances, Appeals Process found below.

Provider Complaints, Grievances, and Appeals Process

A Provider complaint is any verbal or written expression, originating from a Provider and delivered to Molina, voicing dissatisfaction with a policy, procedure, payment, or any other communication or action by Molina. Molina is committed to the timely resolution of all Provider complaints. Molina will not take any punitive actions against any Provider who files a Grievance or a Claim Appeal.

Providers may request Molina's Provider Complaints policies and procedures by contacting Molina at (844) 782-2678.

Provider Grievance Process and Timeline

A Provider complaint that is not related to a Claim is considered a Provider Grievance. Provider grievances may include, but are not limited to, dissatisfaction with a policy, procedure, the quality services provided, timeliness or processing of an authorization, and aspects of interpersonal relationships such as rudeness of an employee.

Provider grievances are accepted verbally, in-person, and in writing within thirty (30) calendar days from the date the grievance occurred, or Provider becomes aware of the grievance occurring. Molina will acknowledge the Provider Grievance within three (3) business days from receipt. Molina will address each Provider Grievance, resolve, and provide written notice within thirty (30) calendar days.

Provider Appeal Process and Timeline

A Provider complaint that is related to a Claim, such as processing, payment, or non-payment of a Claim, is considered a Provider Appeal. Provider appeals are requests to investigate the outcome of a finalized Claim.

Provider Appeals are accepted electronically and in writing within ninety (90) days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA). Molina will acknowledge Provider Appeals within three (3) business days from receipt. Molina will address each Provider Appeal, resolve, and provide written notice within thirty (30) calendar days. Molina will adjudicate each appealed claim to a paid or denied status within thirty (30) business days of receiving notice of a resolution.

Providers are encouraged to submit Provider Appeals electronically, using the Availity Essentials portal. Alternatively, Provider Appeals may be submitted using the form located on the MolinaHealthcare.com website.

The item(s) being submitted should be clearly marked as a Provider Appeal and must include the following documentation:

- Any documentation to support the adjustment of the claim and a copy of the authorization form (if applicable) must accompany the appeal request.
- The Claim number clearly marked on all supporting documents.

Provider Appeals shall be submitted at:

- Availity Essentials portal: Provider.MolinaHealthcare.com
- Fax: (833) 832-1517
- Mail: Molina Healthcare of Nebraska, Inc
  Appeals & Grievances Unit
  PO Box 182273
  Chattanooga, TN 37422

If you would like a hard copy of the Provider Complaint System Policies and Procedures, please contact your Provider Relations representative, or reach out to the Provider Services department. You can also find a copy on our website at MolinaHealthcare.com/NE.

Cost Recovery Disputes and Correspondence:

Molina Healthcare of Nebraska, Inc.
PO Box 2470
Spokane, WA 99210-2470

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the appropriate Agency as needed.

PRACTITIONER CREDENTIALING AND RECREDENTIALING

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

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

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

Non-Discriminatory Credentialing and Recredentialing

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

Types of Practitioners Credentialed & Recredentialed

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

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

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

Credentialing Turnaround Time

Molina will completely process applications from all provider types within thirty (30) days of receipt of a complete application. A complete credentialing application includes all necessary documentation and attachments. "Completely process" means that Molina must:

- Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee.
- Deny the application and ensure that the provider is not used by Molina.

Criteria for Participation in the Molina Network

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

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

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete and a discontinue notice will be sent.

- **Application** – Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification, or Registration** – Practitioners must hold a current and valid license, certification, or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located, and the State the Member is located.
- **DEA or CDS Certificate** – Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every State where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA/CDS certificate and never had any disciplinary action taken related to their DEA and/or CDS or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training** – Practitioners must have satisfactorily completed a residency training from an accredited training program in the specialty in which they are practicing. Molina only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, Podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **Fellowship Training** – Fellowship training is verified when a practitioner will be advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.

- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery (ABOMS?)
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed training from an accredited program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), or as an Urgent Care or Wound Care Practitioner. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with Molina.
- **Work History** – Practitioners must supply the most recent five (5) years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice History** – Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioners must disclose a full history of all license, certification, and/or registration

actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners 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. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioners activities on Molina's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions, including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against person such as murder, rape, assault, and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit which results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of initial credentialing, practitioner must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioners must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

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

Molina will notify the Practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board

certification actions, sanctions, or exclusions. Molina is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

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

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

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

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

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

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

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Practitioner are documents which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

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

Notification of Credentialing Decisions

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

Recredentialing

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

Excluded Providers

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

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

Ongoing Monitoring of Sanctions and Exclusions

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

- The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- The OIG High Risk list – Monitor for individuals or facilities who refused to enter into a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- State Medicaid Exclusions – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- Medicare Exclusion Database (MED) – Monitor for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Practitioner Database – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- System for Award Management (SAM) – Monitor for Practitioners sanctioned by SAM.

Molina also monitors the following for all Practitioner types between the recredentialing cycles:

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Provider Appeal Rights

In cases where the Professional Review Committee denies initial participation in the network, the Practitioner is sent a certified letter describing the reason for denial and is provided an opportunity to formally request a reconsideration.

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to Laws or regulations.

ORGANIZATIONAL CREDENTIALING AND RECREDENTIALING

Types of Organizational Providers Credentialed & Recredentialed

Organizational Providers to be assessed include, but are not limited to:

- Hospitals – all types including psychiatric and specialty
- Home health care agencies
- Skilled nursing facilities/nursing homes
- Free-standing ambulatory surgical centers (independent legal entity not physically attached to another health care institution) (ASC)
- Hospices
- Clinical Laboratories
- Comprehensive outpatient rehabilitation facilities (CORF)
- Outpatient physical therapy and speech pathology Providers
- Pharmacies
- Providers of end-stage rental disease services
- Providers of outpatient diabetes self-management training
- Portable X-ray suppliers
- Rural health clinics (RHC)
- Federally qualified health centers (FQHC)
- Urgent care centers
- Telemedicine providers
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed facility
- Behavioral Healthcare Providers providing inpatient, residential, outpatient and/or ambulatory mental health and/or substance abuse treatment services

LTSS Providers to be assessed include, but are not limited to:

- Adult day care centers
- Assisted living facility services
- Adult family care homes
- Case Management agencies
- Chore providers, including pest-control contractors
- Suppliers of consumable supplies
- Environmental accessibility contractors
- General contractors
- Home-delivered meal services
- Home health agencies
- Home medical equipment services
- Homemaker/companion services
- Hospices

- Non-emergency/non-traditional transportation service providers
- Nurse registry
- Nutrition/dietician
- Skilled nursing facility
- Therapy services (occupational, physical, respiratory and speech)

Criteria for Participation in the Molina Network

Molina has established criteria and sources used to verify criteria for the evaluation and selection of Providers for participation in the Molina network. These criteria have been designed to assess a Provider's ability to deliver care. Providers must meet the following criteria to be eligible to participate in the Molina network. The Provider has the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina provider network.

- **NPI** - Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS) with the exception of atypical organizations where NPI is not required.
- **Medicaid Enrollment** - Provider must be currently enrolled with the state as a Medicaid Provider in every state where they will provide services to Molina Members unless the state doesn't require that particular provider type to be enrolled in order to provide services to Medicaid Members.
- **Accreditation** - Provider must meet one of the following criteria:
  - Provider must be reviewed and approved by an accrediting body deemed by CMS.
  - Provider must have a CMS or state review completed in last three (3)-years.
  - Provider must pass an onsite quality review conducted by Molina with a score of 80% or better.
  - Provider is located in a rural area as defined by the U.S. Census Bureau.
- **Disclosure of Ownership/Controlling Interest** - If the Provider is not required to be enrolled in Medicaid, Molina will collect the Disclosure of Ownership/Controlling Interest Form.
- **Good Standing with State and Federal Regulatory Bodies** - If a license, certification or registration is required to operate in the state in which the Provider will be providing services to Molina Members, that license, certification and/or registration must be current and valid. For Provider types not licensed, certified or registered by a state regulatory board, the Provider must have a current and valid occupational license or other evidence of authority to do business within the scope of contracted service(s).
- **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. State Medicaid sanctions prior to January 1, 2011 do not apply. Molina does not employ or contract with Providers excluded from participation in Federal health care programs as outlined in the Social Security Act Sec. 1128 or Sec 1128A.

Once all documentation has been received and meets criteria as stated above, each assessment file is quality reviewed by Molina staff to ensure completeness and to validate the organizational Provider meets all criteria to participate in the Molina network. Once the quality review has been completed, the Medical Director reviews a formal report listing the organizational Providers for decision regarding participation in the network.

Molina formally reassesses its organizational Providers every thirty-six (36)-months following the same process outlined above. Molina will start the reassessment process at least three (3)-months prior to the due date.

DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

- Utilization Management
- Credentialing and Recredentialing
- Claims
- Complex Case Management
- CMS Preclusion List Monitoring
- Other Clinical and Administrative Functions

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by Molina Delegation Oversight Staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

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

PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high-quality, cost-effective drug therapy. Molina works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. The committee voting membership consists of external physicians and pharmacists from various clinical specialties. In addition, the Nebraska Medicaid Pharmacy and Therapeutics Committee manages medications listed on the state Preferred Drug List (PDL).

Pharmacy Network

Prescription and certain over-the-counter drugs are covered for Molina Members. Members must use their Molina ID card to get prescriptions filled. Molina's network includes, retail, mail, long-term care and specialty pharmacies. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (844) 782-2678.

Drug Formulary

Molina keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit that is in alignment with Nebraska Medicaid preferred drug list (PDL). The list shows the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization or have limitations on age, dosage and/or quantities. The pharmacy program does not cover all medications. For a complete list of covered medications please visit MolinaHealthcare.com.

Information on procedures to obtain these medications is described within this document and also available on the Molina website at MolinaHealthcare.com.

Formulary Medications

Formulary medications with prior authorization may require the use of first-line medications before they are approved. Information on procedures to obtain these medications is described within this document and is also available on the Molina website at MolinaHealthcare.com.

Quantity Limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits can be found in the formulary document. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a prior authorization form which is available on the Molina website at MolinaHealthcare.com. Clinical evidence must be provided and is considered when evaluating the request to determine Medical Necessity. The use of manufacturer's samples of Non-Formulary or "Prior Authorization Required" medications does not override Formulary requirements.

Generic Substitution

Generic drugs should be dispensed when preferred. If the use of a particular brand name non-preferred drug becomes Medically Necessary as determined by the Provider, prior authorization must be obtained through the standard prior authorization process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the prior authorization process.

Medications Not Covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit. Specific exclusions can be found in the formulary at MolinaHealthcare.com.

Submitting a Prior Authorization Request

Molina will only process completed prior authorization request forms. The following information MUST be included for the request form to be considered complete:

- Member first name, last name, date of birth, and identification number.
- Prescriber first name, last name, NPI, phone number, and fax number.
- Drug name, strength, quantity, and directions of use.
- Diagnosis.

Molina's decisions are based upon the information included with the prior authorization request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the prior authorization form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication prior authorization Request form to Molina at (877) 281-5364. A blank Medication prior authorization Request Form may be obtained by accessing MolinaHealthcare.com or by calling (844) 782-2678.

Member and Provider "Patient Safety Notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA-accredited organization.

Specialty Pharmaceuticals, Injectable and Infusion Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider. Some of these same medications may be covered through the medical benefit using Healthcare Common Procedure Coding System (HCPCS) via paper or electronic medical Claim submission. Medical Claims submitted for specialty medications must follow established medical billing processes, using the correct HCPCS codes, NDC codes and billing units for the submitted medication where applicable.

Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will

first identify Member eligibility, any Federal or State regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

Newly FDA approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a Claim to Molina for reimbursement.

Molina completes Utilization Management for certain Healthcare Administered Drugs. For any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the prior authorization list.

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. In addition, all Nebraska Providers who prescribe controlled substances to a Medicaid Member must check the prescription drug monitoring program (PDMP) before prescribing a controlled substance. A Provider may, however, use a delegate to check the PDMP. Exemptions to this requirement include Members receiving cancer treatment, hospice/palliative care, and long-term care facilities. If not able to check the PDMP, then the Provider is required to document a good faith effort, including reasons why they are unable to conduct the check, and may be required to submit documentation upon request.

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

Compounds

Compounded prescriptions must be submitted online and each active ingredient must have an active and valid NDC. Compounded medications may be subject to prior authorization based on the ingredients submitted. Compounds that have a commercially available product are not reimbursable. Pharmacy Providers can access detailed instructions on how to submit a compound claim by accessing the CVS provider website at caremark.com/pharmacists-medical-professionals.html.

Prospective DUR Response Requirements

Molina is committed to providing a safe and extensive pharmacy benefit. Our pharmacy program will utilize prospective and concurrent drug utilization review (DUR) edits to detect potential problems at the point of service. All DUR messages appear in the Claim response utilizing National Council for Prescription Drug Programs (NCPDP) standards. This allows the Provider to receive and act on the appropriate DUR conflict codes. Pharmacy Providers can find detailed instructions on the DUR system by accessing the CVS Provider Manual at caremark.com/pharmacists-medical-professionals.html.

REVISION HISTORY

Version	Date	Revision Information
1.0	11/30/2023	Initial Version

Molina Healthcare of Nebraska, Inc.
14748 W Center Rd, Suite 104
Omaha, NE 68144