PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Washington, Inc.

(Molina Healthcare or Molina)

Apple Health (Medicaid) 2023

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" have the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated annually but may be updated as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 09/2023

MHW Part #2206-2309
MHW-9/5/2023

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1. CONTACT INFORMATION

Molina Healthcare of Washington, Inc.
PO Box 4004
Bothell, WA 98041-4004

Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Services representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.
Availity Essentials portal: provider.Molinal-lealthcare.com
Phone: (855) 322-4082

Member Services Department

The Member Services department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs) and Member complaints. Member Services representatives are available 7:30 a.m. to 6:30 p.m. Monday through Friday, excluding State holidays. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.
Phone: (800) 869-7165, TTY/TDD: 711

Claims Department

Molina strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or the Availity Essentials portal) whenever possible.

- Access the Availity Essentials portal at provider.MolinaHealthcare.com
- EDI Payer ID 38336

To verify the status of your Claims, please use the Availity Essentials portal. Claims questions can be submitted through the chat feature on the Availity Essentials portal or contact Provider Services.

Provider Information Team

The Provider Information team should be contacted for demographic updates such as: new billing or service locations addresses, TIN changes, adding a provider to a group that does not require credentialing as well as individual provider and group terminations.

Please email the appropriate form below for demographic updates to MHWProviderInfo@MolinaHealthcare.com:

Provider Change Form: molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/MHW-Provider-Change-Form.pdf

Termination Notification Form: molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/Termination-Notification-Form.pdf

Claims Recovery Department

The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.
Claims Recovery correspondence mailing address:

Molina Healthcare of Washington, Inc.
Claims Recovery Department
PO Box 2470
Spokane, WA 99210-2470
Phone: (866) 642-8999

Refund Checks Lockbox
Molina Healthcare of Washington
PO Box 30717
Los Angeles, CA 90030-0717

Fax Number:
(888) 396-1520

Compliance and Fraud AlertLine

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

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802
Phone: (866) 606-3889

Online: MolinaHealthcare.alertline.com

Credentialing Department

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

Nurse Advice Line

This telephone-based Nurse Advice Line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week to assess symptoms and help make good health care decisions.
Phone: (888) 275-8750
TTY/TDD: 711 Relay

Health Care Services Department

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

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

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

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

Availity Essentials portal: provider.MolinaHealthcare.com
Medical/Behavioral Services Fax: (800) 767-7188
Inpatient Census Fax: (800) 413-3806
NICU Fax: (877) 731-7220
Transplant Fax: (877) 813-1206
Advanced Imaging Fax: (877) 731-7218
Exception: *If the Member's PCP belongs to a delegated medical group/Independent Practice Association (IPA), the Provider should contact that medical group/IPA for Authorization guidance.*

Health Management

Molina's Health Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs.
Phone: (866) 891-2320

Behavioral Health

Molina manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us directly at (888) 275-8750 (English) or (866) 648-3537 (Spanish). Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card.

Pharmacy Department

Prescription drugs are covered through CVS Caremark. A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina.
Phone: (855) 322-4082
Fax: (800) 869-7791

Caremark Pharmaceuticals

When a Molina Member needs an injectable medication, the prescription can be submitted to Caremark by fax. For a current listing of available injectable medications, please check the web address below.

Caremark
Fax: (800) 869-7791
Online: caremark.com

Vision Service Plan (VSP®)

Molina is contracted with VSP® to provide routine vision services for our Members. Members who are eligible may directly access a VSP® network Provider.

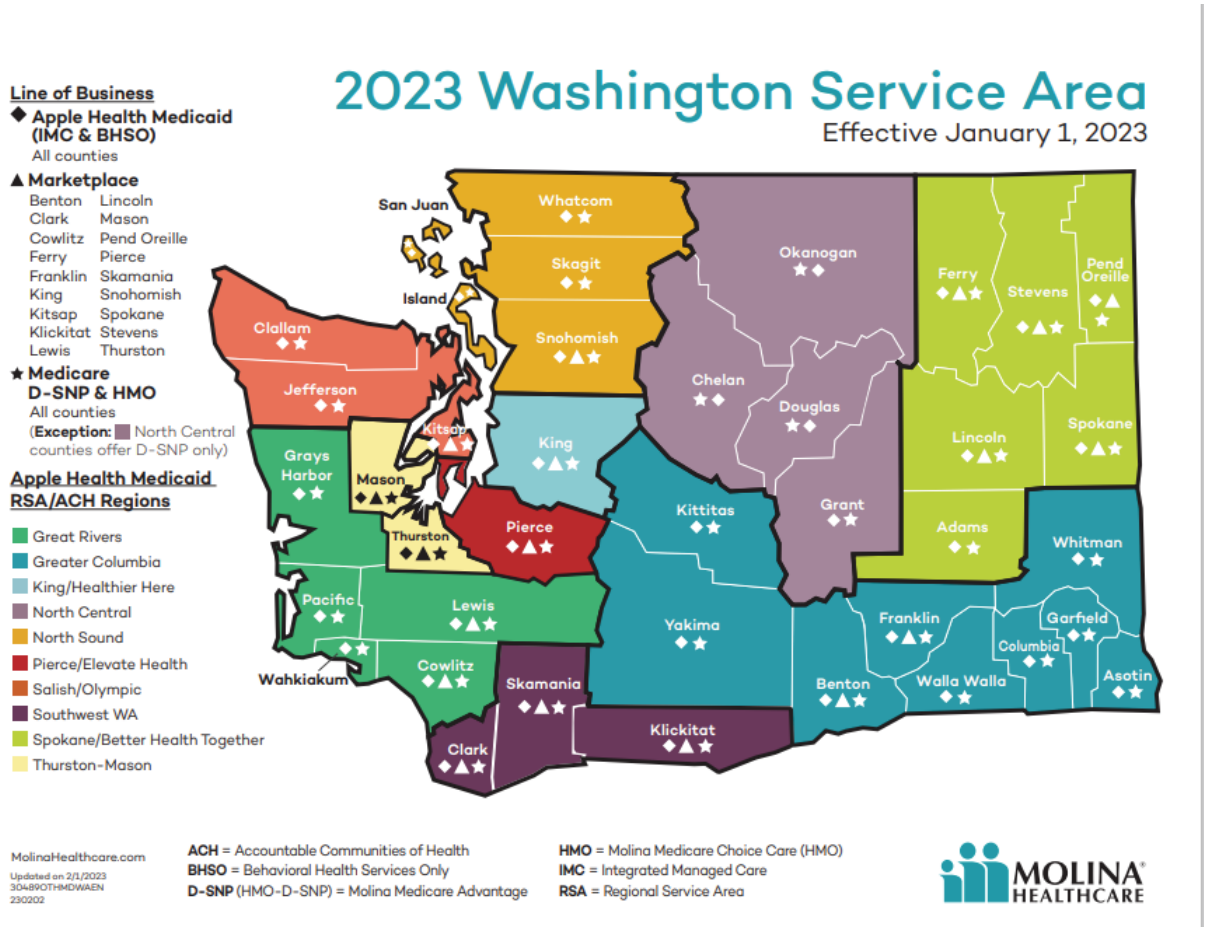
VSP®
Phone: (800) 615-1883

EXCEPTION: *If the Member's PCP belongs to a delegated medical group/IPA the Provider should contact that medical group/IPA for Authorization guidance.*

Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Program.
Phone: (800) 869-7175 ext 141428
Fax: (800) 461-3234

Molina Healthcare of Washington, Inc. Service Area



2. PROVIDER RESPONSIBILITIES

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 investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Molina's Civil Rights Coordinator.

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
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:
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 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 minimum 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 https://molina.sapphirethreesixtyfive.com/?ci=wa-medicaid&locale=en_us&network_id=40&geo_location=47.6569,-117.372 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.

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 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 is able to 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.

National Provider Identifier (NPI) HCA Billing and Non-Billing Enrollment Requirements

Per federal regulation (42.C.F.R. 455.410(b)) providers who have a contract with the state's Medicaid agency or a contract with a Managed Care Organization (MCO) that serve Medicaid Clients must enroll with the Washington State Health Care Authority (HCA) under a Non-Billing or Billing agreement. The provider's National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Molina will deny/reject all claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at: hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider.

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 required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Availity Essentials portal within 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. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.).

- Increasing accuracy of data and efficient information delivery.
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time and enabling Claims to 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 through your EDI clearinghouse using Payer ID 38336, refer to our website MolinaHealthcare.com for additional information.

While both options are embraced by Molina, submitting Claims via the Availity Essentials portal (available to all Providers at no cost) offers a number of additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Availity Essentials portal Claims submission includes the ability to:

- Add attachments to Claims.
- Submit corrected Claims.
- Easily and quickly void Claims.
- Check Claims status.
- Receive timely notification of a change in status for a particular Claim.
- Ability to Save incomplete/un-submitted Claims.
- Create/Manage Claim Templates.

For more information on EDI Claims submission, see the **Claims and Compensation** section of this Provider Manual.

Electronic Payment Requirement

Participating Providers are strongly encouraged 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 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 at (888) 834-3511 or edi@echohealthnc.com. 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 at (888) 834-3511 or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Washington 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 the ECHO Health Customer Services team at (888) 834-3511.

As a reminder, Molina's Payer ID is 38336.

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-year lookback.

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

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 (CMS1500) and Institutional (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
- 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

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. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).
For additional information please refer to the **Member Rights and Responsibilities** section of this Provider Manual.

Member Information and Marketing

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

Member Eligibility Verification

Possession of a Molina ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit

eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity Essentials portal at provider.MolinaHealthcare.com
- Molina Provider Services automated IVR system at (855) 322-4082

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

Member Cost Share

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 Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management programs, including all policies and procedures regarding Molina's facility admission, prior authorization, 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.

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

In Office Laboratory Tests

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

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

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

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

Referrals

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.

Continuity and Coordination of Provider Communication

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

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.

PCP Role in Screening, Identifying, Intervening and Referring Members for Mental Health and Substance Use Disorder Services

It is the primary care provider's (PCP) responsibility to routinely screen members to assess whether they have any MH or SUD symptoms. If the results of the assessment indicate MH or SUD symptoms, the PCP is responsible for providing treatment or referring the member to the appropriate mental health or substance use disorder services, taking into consideration the member's motivation and interest in obtaining care. Providers can reference the Molina

Provider Online Directory (POD) for in-network behavioral health providers. PCP's should support and encourage the member toward reduction in symptoms related to MH or SUD to improve health outcomes and to support recovery. PCP's should educate members about the benefits of treating BH conditions as well as the risks if not treated. Information on whole person care, the principles of recovery and provider strategies to support recovery can be found at: integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care as well as through the University of WA AIMS Center website: aims.uw.edu. Additional information pertaining to substance use disorder can be found at asam.org. For additional information about advancing your clinic's ability to provide integration behavioral health and general health care, consult the Washington Integrated Case Assessment (WA-ICA): https://waportal.org/partners/home/WA-ICA. Please contact your assigned provider services representative if you are interested in additional resources to support this work with our members.

Bright Heart Health

Molina Healthcare of Washington has partnered with Bright Heart Health (BHH) to offer adult members Medicated-Assisted Treatment (MAT) via telemedicine. Participating Molina members meet with BHH medical staff and recovery counselors via two-way video in the privacy of a member's home or wherever they choose to receive care. Members can call (844) 884-4474, 24/7.

Referral for Mental Health Services

Molina covers lower intensity outpatient MH services for mild-to-moderate MH conditions including psychotherapy, psychological testing and medication management as well as higher intensity MH services (such as residential or inpatient treatment) for Medicaid members. Members may also self-refer for MH services. Please see the Molina Provider Online Directory (POD) or contact our Molina Member Services for a list of participating mental health providers.

Wraparound with Intensive Services (WISe) Providers

WISe providers are required to follow the program, policies and procedures contained within the Department of Social and Health Services (DSHS) Wraparound with Intensive Services (WISe) Manual, which is available at: hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf. WISe providers must participate in all WISe-related quality activities including but not limited to conducting or participating in a review of WISe services using the WISe Quality Improvement Tool (QIRT) at least once annually.

WISe providers are required to send Molina a notification of any adverse benefit determination (ABD) indicated in the WISe manual within 24 hours of the ABD determination. The WISe Notification form can be found under "Other" at: MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx.

Referral for Substance Use Disorder

Molina covers SUD treatment services including outpatient services, case management, opiate substitution treatment and inpatient/residential treatment. Members may also self-refer for SUD treatment services. Please see the Molina Provider Online Directory (POD) or contact our Molina Member Services, for a list of participating SUD providers

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.

CFR 42 Part 2

Molina requires Providers comply with CFR 42 Part 2 which relates to the privacy of all records relating to the identity, diagnosis, prognosis or treatment of any patient in a substance abuse program that is conducted, regulated or directly or indirectly assisted by any department or agency of the United States.

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

For additional information please refer to the **Provider Dispute Resolution and Member Appeals** section of this Provider Manual.

Participation in Credentialing

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

Providers must notify Molina no less than 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 Care Management
- Participate in the development of Care Management treatment plans

Ensuring Compliance with Washington State Background Check Requirements

In accordance with State Law, Providers are required to submit their Practitioners, employees, volunteers, and/or Subcontractor staff who may have

unsupervised access to children, people with developmental disabilities, or vulnerable adults, as defined by RCW 43.43.830(14), to a criminal history background check through the Washington State Patrol at https://www.wsp.wa.gov/crime/criminal-history/.

Such criminal history background check shall be consistent with RCW 43.43.832, RCW 43.43.834, RCW 43.20A.710, chapter 388-06 WAC and any other applicable statute or regulation.

The Provider shall not give Practitioners, employees, volunteers, and/or Subcontractor staff access to children and/or vulnerable adults until a criminal history background check is performed and a positive result is reported.

3. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the 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 Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, 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, from your local Provider Services representative and by calling Molina Provider Services at (855) 322-4082.

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 con be found here: https://www.molinahealthcare.com/members/wa/en-us/-/media/Molina/PublicWebsite/PDF/members/wa/en-us/Medicaid/Molina-Healthcare-Notice-1557---WA-Medicaid.pdf

3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found here https://www.molinahealthcare.com/members/wa/en-us/-/media/Molina/PublicWebsite/PDF/members/wa/en-us/Medicaid/Molina-Healthcare-Notice-1557WA-Medicaid.pdf
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 https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html; See also, https://www.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: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: https://www.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 its 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 and 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 Contact Center toll free at (800) 869-7165. If Contact Center Representatives are unable to interpret in the requested

language, the Representative will immediately connect you and the Member to a qualified language service Provider.

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

Documentation

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

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend or minor as an interpreter, or refuses the use of interpreter services after notification of 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 & Provider Contact Center, 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 three 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, seven days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly: English line (888) 275-8750, Spanish line (866) 648-3537 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®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventative

4. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following links: https://www.molinahealthcare.com/members/wa/en-us/mem/medicaid/imc/member-handbook.aspx and https://www.molinahealthcare.com/members/wa/en-us/-/media/Molina/PublicWebsite/PDF/members/wa/en-us/bhso/BHSO-Member-Handbook_WEB_nob_FNL_508c.pdf

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

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

For additional information, please contact Molina at (855) 322-4082, 7:30 a.m. to 6:30 p.m. PST. 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 Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

Special Provisions for American Indians and Alaska Natives

If an American Indian/Alaska Native (AI/AN) Enrollee indicates that he or she wishes to have an Indian Health Coverage Programs (IHCP) as his or her PCP, Molina must treat the IHCP as an in-network PCP for the Enrollee regardless of whether the IHCP has entered into a subcontract with Molina.

Molina must honor the referral of an out-of-network IHCP to refer an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)).

In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Molina is required to allow AI/ANs free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to AI/AN Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.

If Indian Health Care Providers (IHCPs) that are Federally Qualified Health Centers (FQHCs) receive an amount from Molina for services provided to an Indian Enrollee of Molina's plan that is less than the total amount the IHCP is entitled to receive (including any supplemental payment under Section 19O2(bb)(5) of the Social Security Act), the state must make a supplemental payment to the IHCP to make up the difference between the amount Molina pays and the amount the IHCP is entitled to receive as an FQHC, whether or not the IHCP has a contract with Molina. If the IHCP is not a FQHCs, and they receive an amount from Molina that is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, the state must make a supplemental payment to the IHCP to make up the difference between the amount Molina pays and the amount the IHCP would have received under FFS or the applicable encounter rate, whether or not the IHCP has a contract with Molina.

Family Planning Services

Molina members can self-refer to any family planning provider within the Molina provider network or to local health departments and family planning clinics paid by the State of Washington.

Enrollee Self Determination

Advance Directives are a written choice for health care. Under Washington State Law, there are two kinds of directives - Durable Power of Attorney for Health Care and Directive to Physicians. Written Advance Directives tell the PCP and other medical Providers how Members choose to receive medical care in the event they are unable to make end-of-life decisions. Each Molina Provider must honor Advance Directives to the fullest extent permitted under Washington State Law. Providers must document the presence of an Advance Directive in a prominent location of the medical record. PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance. Under no circumstances may any

Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an Advance Directive.

- **Durable Power of Attorney for Health Care –** This Advance Directive names another person to make medical decisions on behalf of Members when they cannot make the choices for themselves. It can include plans about the care a Member wants or does not want and include information concerning artificial life-support machines and organ donations. This form must be signed, dated and witnessed by a notary public to be valid.
- **Directive to Physicians (Living Will) –** This Advance Directive usually states the Member wants to die naturally without life-prolonging care and can also include information about any medical care. The form would be used if the Member could not talk and death would occur soon. This directive must be signed, dated and witnessed by two people who know the Member well but are not relatives, possible heirs or health care Providers.
- **Physician Orders for Life Sustaining Treatment (POLST)** - The POLST form represents a way of summarizing wishes of an individual regarding life-sustaining treatment. The form is intended for any individual with a serious illness. It accomplishes two major purposes:
    - It is portable from one care setting to another and it translates wishes of an individual into actual physician orders. An attending physician, ARNP or PA-C must sign the form and assume full responsibility for its accuracy.
- **Five Wishes -** Five Wishes is an easy-to-use legal advance directive document written in everyday language. It helps all adults, regardless of age or health, to consider and document how they want to be cared for at the end of life. five-wishes-sample.pdf (fivewishes.org)

Mental Health Advance Directive

A mental health advance directive is a legal written document that describes what an individual wants to happen if their mental health problems become so severe that they need help from others. This might be when their judgment is impaired and/or they are unable to communicate effectively.

More information including a downloadable form can be found at: hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-advance-directives.

Providers are encouraged to send any advance directive or POA documents to Molina via email to: ServiceFulfillment@MolinaHealthcare.com.

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 obtain informed consent prior to treatment from enrollees or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning Advance Directives (WAC 182-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

5. ELIGIBILITY, ENROLLMENT, DISENROLLMENT

Enrollment

Enrollment in Washington Apple Health Integrated Managed Care (IMC) Medicaid and Behavioral Health Services Only (BHSO) programs

Molina Members are enrolled in a managed care health plan after the Health Care Authority (HCA) determines a Member is eligible for services through Apple Health Medicaid. Members may enroll with Molina if they reside within Molina's Service Area (molinahealthcare.com/providers/wa/medicaid/contacts/Pages/service_area.aspx). To initially enroll with Medicaid, an IMC or BHSO Member, his/her representative or responsible parent/guardian must apply online at wahealthplanfinder.org or call the Customer Support Center at (855) WAFINDER (855-923-4633) or (855) 627-9604 (TTY 711) where they can choose Molina as their health plan. Once a Member is eligible for Medicaid, they may change their health plan up to once per month. Member can change their plan at: wahealthplanfinder.org.

For Apple Health Classic Medicaid coverage (adults over 65, blind or disabled and/or needing long-term services and supports) apply online through Washington Connection at: washingtonconnection.org or call (877) 501-2233.

HCA will enroll all eligible Members with the health plan of their choice. If the Member does not choose a plan, HCA will assign the Member and his/her family to a plan that services the area where the Member resides. The following groups of Members, eligible for medical assistance, must enroll in a managed care plan:

IMC

- Members receiving Medicaid under the Social Security Act (SSA) provisions for coverage of families receiving Apple Health (AH) Family
- Members who are not eligible for cash assistance but remain eligible for Medicaid
- Members receiving Medicaid under the provisions of the ACA effective January 1, 2014 (Apple Health Medicaid Expansion)
- Children from birth through 18 years of age eligible for Medicaid under expanded pediatric coverage provisions of the SSA ("H" Children)
- Pregnant women eligible for Medicaid under expanded maternity coverage provisions of the SSA ("S" Women)
- Children eligible for the Children's Health Insurance Program (CHIP).

- Categorically Needy-Blind and Disabled children and adults who are not eligible for Medicare
- Members who are eligible for Breast and Cervical Cancer Treatment, Categorically Needy Program
- Members who are eligible for Categorically Needy Program, Long Term Care

BHSO

- Dual eligible (Medicare-Medicaid)
- Apple Health foster children, foster alumni and adoption support in Fee-for-Service (FFS) physical health. (NOTE: These clients are managed only by Coordinated Care)
- Members who are eligible for the Medically Needy (spenddown) program
- Non-citizen pregnant women
- Members who are eligible for Institution for Mental Disease (IMD) and other Medicaid eligible long term or residential care

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

Effective Date of Enrollment

Earlier Enrollment allows Members to be enrolled into a plan the same month they become eligible for Medicaid, as opposed to waiting until the next month to be enrolled. Earlier enrollment applies to Members who are new to Medicaid or who have had a break in eligibility and are recertified for Medicaid services. The Member is retro effective to the first of the month they were determined eligible for Medicaid. The current month enrollment is intended to allow the Member continuous enrollment in managed care from the date of enrollment. When a Member changes from one health plan to the next the change will always be effective the first of the following month.

HCA notifies eligible Members of their rights and responsibilities and sends them a booklet at the time of initial eligibility determination. HCA sends Molina a daily list of assigned Members. Molina sends each new Member a Molina Member ID card and welcome kit within 15 days of initial enrollment with Molina. The letter includes important information for the new Member such as how to access their online handbook and how to contact Molina.

Newborn Enrollment

Regardless of what Medicaid program or health plan the Member is enrolled in at discharge (Medicaid Fee-for-Service (FFS) or a managed care plan), the program or plan the Member is enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the Member is discharged to home or a community residential setting. This includes behavioral health residential treatment facilities or a lower level of care, eligibility to receive Medicaid services ends, or the Member no longer meets rehabilitative or skilled criteria applicable to the skilled nursing facility setting.

For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization is responsible for payment of all the newborn's covered inpatient facility and professional services from date of birth until the date the newborn is discharged from an acute care hospital, unless their mother is on FFS Medicaid and the newborn is determined eligible with managed care in the month of birth. If the newborn is not enrolled in managed care in the month of birth, facility costs and professional services will be paid by FFS. A newborn whose mother is receiving services when the baby is born will be enrolled on an Apple Health plan according to Earlier Enrollment rules.

If their mother is not covered during the birth and the newborn is found eligible and enrolled in managed care in the month of birth, the managed care plan will be responsible for all covered inpatient facility and professional services provided to the enrolled newborn starting from the date of birth or admission.

When a newborn is placed in foster care, the newborn will remain enrolled with the Apple Health plan for the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program (provided through Coordinated Care) effective the first of the month following placement of the newborn.

Enrollment Exemption: In some cases, a Member may request exemption from enrollment in a plan. Each request for exemption is reviewed by HCA pursuant to Washington Administration Code (WAC) 182-538-130.

Eligibility Verification

Medicaid Programs

Eligibility is determined on a monthly basis. 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.

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

- Molina Member ID card
- Monthly PCP eligibility listing located on the Provider Portal
- Molina Member Services at (800) 869-7165
- ProviderOne website

Providers may also use a Medical Eligibility Verification (MEV) service. Molina sends eligibility information including PCP assignment to Provider Advantage and Change Health. Some MEV services provide access to online Medicaid Member eligibility data and can be purchased through approved HCA vendors. MEV services provide eligibility information for billing purposes, such as:

- Eligibility status
- Plan enrollment and plan name
- Medicare enrollment
- Availability of other insurance*
- Program restriction information

*Providers should use the Provider Portal and not ProviderOne to verify the availability of other insurance as there is window of time this information may not be reflective in ProviderOne.

HCA updates the MEV vendor list as new vendors develop MEV services. For more information and a current list of HCA vendors visit HCA's website at: General verification I Washington State Health Care Authority

Providers can also access eligibility information for Members free of charge using the HCA's ProviderOne online service. In order to access eligibility on the website you must register online and complete an application. Online enrollment information can be found at: hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider

Eligibility Listing for Medicaid Programs

Eligibility reports are available for viewing at any time on the Provider Portal at: onehealthport.com. The report includes information regarding members assigned to the PCP's at that clinic location. The eligibility reports are refreshed hourly. You can also verify a Member's PCP assignment by looking up the individual member in the Provider Portal. You may also call Molina's Member Services department at (800) 869-7165 to verify eligibility.

PCP Capitation Groups

The below table shows all contracted PCP capitated groups. These groups receive a per member per month capitation payment to manage all primary care services only for their assigned membership. When seeing a new member verify if the member is assigned to a PCP capitated group by looking at their ID card or verifying eligibility on the web portal. If the member is assigned to a PCP capitated group the member must be seen by their assigned PCP or a PCP change needs to be made to the appropriate PCP prior to services being rendered.

PCP Capitation Groups	Acronym
Community Health Associates Spokane	CAP – CHAS
CAP -FCN	CAP – FCN
Moses Lake Community Health Center	CAP – MOSES LAKE CHC
Pacific Physicians	CAP – PACIFIC PHYSICIANS
Pierce Unicare IPA	CAP – PIERCE UNICARE
Rose Medical Group	CAP – ROSE CLINIC
Yakima Valley Farmworkers Clinic	CAP – YVFWC

Identification Cards

An individual determined to be eligible for medical assistance is issued a ProviderOne Services Card by HCA. It is issued once upon enrollment. Providers must use the ProviderOne Client ID on the card to verify eligibility either through the ProviderOne website at: waproviderone.org/ or via a Services Card swipe card reader. Providers must check Member eligibility at each visit and should make note of the following information:

- Eligibility dates (be sure to check for the current month and year)
- The ProviderOne Client ID number
- Other specific information (e.g. Medicare, IMO, BHSO, etc.)

Medical assistance program coverage is not transferable. If you suspect a Member has presented a ProviderOne (Services Card) belonging to someone else, you should request to see a photo ID or another form of identification. To report suspected Member fraud, call the HCA Medicaid Fraud Hotline at (360) 725-0934 or email WAHEligibilityFraud@hca.wa.gov. Do not accept a Services Card that appears to have been altered.

All Members enrolled with Molina receive an ID card from Molina in addition to the Services Card. Molina sends an identification card for each family Member covered under the plan. The Molina ID card has the name and phone number of the Member's assigned PCP.

Members are reminded to carry both ID cards (Molina ID card and Services Card) with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Possession of a Services 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.

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

Disenrollment

Voluntary Disenrollment

Members may request a different health plan via wahealthplanfinder.org or may call or submit a written request to HCA to disenroll from managed care completely. Members whose enrollment is terminated will be prospectively disenrolled. HCA notifies Molina of all terminations. Neither the Provider nor Molina may request voluntary disenrollment on behalf of a Member.

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

Involuntary Disenrollment

When a Member becomes ineligible for enrollment due to a change in eligibility status or if the Member has comparable coverage, HCA will disenroll the Member and notify Molina.

Molina may request the involuntary termination of a Member for cause by sending a written notice to HCA. HCA will approve/disapprove the request for termination within 30 business days of receipt of request. Molina must continue to provide medical services to the Member until they are disenrolled. HCA will not disenroll a Member based solely on an adverse change in the Member's health status or the cost of his/her health care needs. HCA may involuntarily terminate the Member's enrollment when Molina has substantiated all the following in writing:

- The Member's behavior is inconsistent with Molina's rules and regulations, such as:
  A. Intentional misconduct
  B. Purposely putting the safety of members, Molina staff or providers at risk
  C. Refusing to follow procedures or treatment recommended by provider and determined by Molina Medical Director to be essential to member's health and safety
- Molina has provided a clinically appropriate evaluation to determine whether there is a treatable condition contributing to the Member's behavior and such evaluation either finds no treatable condition to be contributing or, after evaluation and treatment, the Member's behavior continues to prevent the Provider from safely or prudently providing medical care to the Member.
- The Member received written notice from Molina of its intent to request disenrollment, unless the requirement for notification has been waived by HCA because the Member's conduct presents the threat of imminent harm to others. Molina's notice to the Member must include the following:
  A. The Member's right to use Molina's appeal process to review the request to terminate the enrollment
  B. The Member's right to use the HCA hearing process

A Member whose enrollment is terminated at any time during the month is entitled to receive covered services at Molina's expense through the end of that month. If the Member is inpatient at an acute care hospital at the time of disenrollment and the Member was enrolled with Molina on the date of admission, Molina and its contracted medical groups/IPAs shall be responsible for all inpatient facility and professional services from the date of admission through the date of discharge from the hospital unless eligibility to receive Medicaid services ends.

Supplemental Security Income (SSI)

SSI is a federal income supplement program funded by general tax revenues. It is designed to help aged, blind and disabled people who have little or no income and provides cash to meet basic needs for food, clothing and shelter. Members

who ore eligible for SSI receive medical care through Medicaid FFS and Apple Health Blind Disabled (AHBD) (only non-dual blind and disabled Members) but are not eligible for Apple Health Family (AHFAM), Apple Health with Premium (AHPREM) or Apple Health Adult (AHA).

When identified by case managers, Molina assists Members in pursuing SSI approvals. Until SSI is approved for the Member, Molina and its contracted medical groups/IPAs are financially responsible for all costs associated with medical management of the Member.

AHFAM, AHPREM and AHA adults who are determined to be SSI eligible due to being blind or disabled will prospectively change eligibility categories to AHBD (blind disabled) and will continue coverage through their designated health plan. Adults determined to be SSI eligible due to being aged will be dis-enrolled prospectively and HCA will not recoup any premiums from Molina. Molina and its contracted medical groups/IPAs will be responsible for providing services until the effective date of disenrollment.

If terminated, disenrollment processed on or before the HCA cut-off date, will occur the first day of the month following the month in which the termination is processed by HCA. If the termination is processed after the HCA cut-off date, disenrollment will occur the first day of the second month following the month in which the termination is processed by HCA.

Molina engages with vendors Centauri Health Solutions and Pacific Disability Resources (PDR) who reach out to Members that are identified as potentially SSI eligible individuals. The vendors assist the Member with completing the needed paperwork and tracking progress of the SSI application.

Maternity and Newborn Coverage

Obstetrical (OB) care is covered for all IMC members. An IMC newborn is automatically covered through the end of the month in which the 21st day of life falls. Continued coverage is contingent upon the mother reporting the newborn through the wahealthplanfinder.org portal or by calling (855) 923-4633. If eligible, the newborn will receive a Services Card. If the baby is not reported, medical coverage ends at the end of the month in which the 21st day of life falls, unless the baby is in the hospital in which case coverage ends at discharge. If the mother changes health plans within the initial three months of life, the newborn's coverage will follow the mother's coverage.

PCP Assignment

Molina Members have the right to choose their own PCP. If the Member does not choose a PCP, Molina assigns one to the Member based on reasonable proximity to the Member's home and prior assignments. Newborns are assigned to the mother's PCP through the first full month of coverage following discharge from the hospital. Newborns enrolled in a Molina plan may receive services from any Molina contracted PCP during the first 60 days after birth.

Molina will pay for services provided to a Member by any PCP that participates with Molina or one of the capitated medical groups/IPAs, regardless if the Member is currently assigned to that PCP.

If a Member would like to know about a PCP's medical training, board certification or other qualifications, the Member can call Member Services. This includes PCPs, specialists, hospitals and other Providers.

PCP Change

A Member can change their PCP at any time with the change being effective no later than the beginning of the month following the Member's request for the change. If the Member is receiving inpatient hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital. The guidelines are as follows:

1. If a Member calls to make a PCP change prior to the 15th of the month, the Member will be allowed to retroactively change their PCP to be effective the first of the current month, provided the Member is new to Molina that month.
2. If a Member calls to change the PCP and has been with Molina for over 15 days, the PCP change will be made prospectively to the first of the next month.
3. If the Member was assigned to the incorrect PCP due to Molina's error, the Member can retroactively change the PCP, effective the first of the current month.

Newborn PCP Assignment

- Newborns will be assigned to the mother's PCP through the first full month of coverage following discharge from the hospital.
- The mother may select a different PCP for her newborn effective the first full calendar month after discharge from the hospital by notifying Member Services.

- While assigned to the mother's PCP, the newborn may see the chosen PCP as long as the PCP is participating with Molina or one of the capitated medical groups/IPAs.
- Molina and its capitated medical groups/IPAs will be responsible for paying the PCP services provided during this time period.

Financial Responsibility and Medical Management Authority

If the mother's PCP is part of a contracted medical group/IPA, that group/IPA will be financially responsible for covered services and has the authority to medically manage the newborn until the end of the first full calendar month of coverage after discharge from the hospital. If a hospitalized newborn loses eligibility, the contracted medical group/IPA or Molina is responsible for coverage until the newborn is discharged from the acute care facility. A transfer from one acute care facility to another is not considered a discharge.

PCP Dismissal

A PCP may dismiss a Member from his/her practice based on the following reasons. The issues must be documented by the PCP:

- Repeated "No-Shows" for scheduled appointments
- Inappropriate behavior

This Section does not apply if the member's behavior is resulting from his or her special needs, except when his or her continued assignment to the PCP seriously impairs the PCP's ability to furnish services to either the individual member or other members. The Member must receive written notification from the PCP explaining in detail the reasons for dismissal from the practice. The provider may use the approved "Dismissal Letter" located on the Molina website at: https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/Dismissal-Letter.pdf.

The PCP may use their own dismissal letter after approval by Molina. A copy of the dismissal letter should be faxed to Member Services at (800) 816-3778. Molina will contact the Member and assist in selecting a new PCP. The current PCP must provide emergency care to the Member for thirty days during this transition period.

If a PCP wants to dismiss a member for any other reason, please contact your Provider Services representative.

PCP Panel Closure - "New Members"

If a PCP determines that they are unable to accommodate "new" Members he or she can elect to close his or her panel. Molina must receive 30 days advance notice from the provider. Once the panel is closed, no new Members will be assigned to the PCP with the following exceptions:

- Family Members of existing Members will continue to be assigned.
- Members who were previously assigned to the PCP prior to a loss of eligibility will continue to be "reconnected" to the PCP.
- Members who a PCP has provided services two or more times in a 12-month period. The system automatically re-assigns the member based on claims data.

To request the change in panel status (closed or open), the provider must fill out the Provider Change Form and email it to: MHWProviderInfo@MolinaHealthcare.com. The form must include the reason and the effective date of the status change.

PCP Panel Closure - "New & Previously Assigned Members"

In the event a PCP determines they are unable to serve not only New Members, but also Members who have been previously assigned, the PCP must close his or her panel by providing immediately completing the Provider Change Form and emailing it to: MHWProviderInfo@MolinaHealthcare.com.

Molina will identify those Members for potential re-assignment to another PCP using the following objective criteria:

- Members were assigned to the PCP within the last 1-6 months
- Member has never been seen by the PCP and does not have a scheduled appointment
- Member is not a family member of a Member being actively seen by the PCP

The current PCP must provide emergency care to the Member for 30 days during this transition period.

6. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Washington Apple Health Integrated Managed Care (IMC) Members including:

- Apple Health IMC with Premium (IMC-PREM)
- IMC Family/Pregnancy Medical (IMC-AH)
- IMC Adult (IMC-AHA)
- IMC Aged, Blind, Disabled (IMC-AHBD)
- Behavioral Health Services Only (BHSO)

Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization, please reference the Prior Authorization tools located on the Molina website and the Provider Portal. You may also contact Molina at (855) 322-4082, Monday through Friday, 7:30 a.m. to 6:30 p.m.

In addition to receiving health care services from providers who contract with Molina, Members may self-refer and receive certain benefits through local health departments, school-based health centers, family planning clinics or Indian Health Care Providers (IHCP) for the following:

- Family planning services and supplies
- Immunizations
- Tuberculosis (TB) screening and follow-up care
- Sexually Transmitted Disease (STD) screening and treatment services
- HIV or AIDS testing
- Behavioral health services
    - Assessment and intake
- Women's health services
- Crisis response services
    - Crisis intervention
    - Crisis respite
    - Investigation and detention services
    - Evaluation and treatment services

Washington Apple Health

Washington Apple Health is the name used in Washington State for Medicaid, the Children's Health Insurance Program (CHIP) and the state-only funded health care programs and includes Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO). It is a prepaid, comprehensive system

of medical and behavioral health care delivery which includes preventive, primary, specialty and ancillary health services. HCA contracts with a number of health plans to provide health care to eligible Client groups.

IMC includes Clients eligible for:

- Temporary Assistance for Needy Families (TANF)
- Pregnant women with family incomes up to 193 percent of the federal poverty level (FPL)
- Children with family incomes up to 312 percent of FPL not eligible for other Medicaid programs
- Blind and Disabled (SSI) children and adults not eligible for Medicare
- Adult Medical or Medicaid Expansion up to 133 percent of FPL
- Breast and Cervical Cancer Treatment, Categorically Needy Program
- Categorically Needy Program, Long Term Care

Clients receive their health benefits by accessing care through providers who contract with a health plan.

Services Covered by Molina

Molina covers the services described in the Benefit Index. If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located on the Molina website and Availity Essentials Provider Portal. You may also contact Molina at (855) 322-4082, Monday through Friday, 7:30 a.m. to 6:30 p.m.

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. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

BHSO is for specialty behavioral health (mental health and substance use disorder) services only. BHSO Members receive their physical health care and all medication through their primary medical coverage such as; Medicare (traditional or Part C), private health insurance or the Medicaid fee-for-service while they meet spenddown requirements before they are eligible for Apple Health benefits.

Under the BHSO line of business, providers con bill MHW for high-acuity behavioral health services and bill ProviderOne for low acuity behavioral health services, which fall under the member's physical health benefits package.

For more information on how to identify the correct payer for low acuity and high acuity services, go to https://www.hca.wa.gov/assets/billers-and-providers/providers-identify-payer-table.pdf. The Health Care Authority Mental Health Services Billing Guide can be located at the following website: Mental Health Services Billing Guide (wa.gov)

Link(s) to Benefit Information

The following web link provides access to the benefit information for the Benefit Index Apple Health IMC and BHSO offered by Molina in Washington state.

2023 Apple Health IMC Benefits At-A-Glance

2023 BHSO Benefits At-A-Glance

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 prescriber will be notified of Molina's decision within 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 24 hours of receiving the complete request.
- Members will also have the right to appeal a denial decision, per any requirements set forth by the state of Washington.
- Molina will allow a 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 72-hour option is utilized. This procedure will not be allowed for routine and continuous overrides.

Specialty Drug Services

Many self-administered and office-administered injectable products require prior authorization. In some cases they will be made available through a vendor, designated by Molina. More information about our prior authorization process, including a link to the Prior Authorization Request Form, is available in the **Healthcare Services** section of this Manual. Physician administered drugs require the appropriate National Drug Code (NDC) with the exception of vaccinations or other drugs as specified by CMS.

Injectable and Infusion Services

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

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

Access to Behavioral Health Services

Members in need of access to Behavioral Services is available through PCP referral for services or Members can self-refer by calling Molina's Member Contact Center at (800) 869-7165. 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 detail regarding Covered Services and any limitations can be obtained in the benefit information linked above or by contacting Molina. If in-patient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation, and inpatient Member cost share will apply.

Emergency Mental Health or Substance Use Services

Members are directed to call 911, 988 or go to the nearest emergency room if they need Emergency Services for mental health or substance use . Examples of emergency mental health or substance use 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 24 to 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.

Washington Recovery Help Line

The Washington Recovery Help Line is the consolidated help line for substance use , problem gambling and mental health, as authorized and funded by The Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery. It is a 24-hour crisis intervention and referral line for those struggling with issues related to mental health, substance use , and problem gambling. Professionally trained volunteers and staff provide confidential support and referrals to detox, treatment, and recovery support groups. WA state residents can access services 24 hours a day at (866) 789-1511 or warecoveryhelpline.org.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance or air transports. See Ambulance Transportation Billing Guide (wa.gov) for more information.

Non-Emergency Medical Transportation

For Molina Apple Health Members to have non-emergency medical transportation (NEMT) as a Covered Service, the Health Care Authority (HCA) covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). Examples of non-emergency medical

transportation include, but are not limited to, litter vans and wheelchair accessible vans. If you want to arrange transportation for a Member to travel to/from their healthcare service provider, contact the regional transportation broker for the Member's county of residence. Refer to https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/transportation-services-non-emergency.

Preventive Care

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

https://www.molinahealthcare.com/providers/wa/medicaid/resource/guide_prevent.aspx. We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (866) 891-2320 (TTY/TDD: 711)

Immunizations

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

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

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

Well Child Visits and EPSDT Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until 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. hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

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 Washington state Recommended Childhood Immunization Schedule, as appropriate.
- Comprehensive unclothed physical exam.
- Laboratory tests as specified by the AAP, including screening for lead poisoning.
- Health education.
- Vision screenings.
- Hearing screenings.
- Oral health.

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

We need your help conducting these regular exams in order to meet the Health Care Authority 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.

Vaccines for Children

Since 1990, the Washington State Immunization Program has been providing vaccines to all children under the age of 19, regardless of their income level, through a combination of state and federal funds. In 1994, the federal government provided an additional funding source through the Vaccines for Children (VFC) program. The Centers for Disease Control and Prevention (CDC), which provides VFC funding, has developed strict accountability requirements from the state, local health jurisdictions and individual providers. Molina Providers are encouraged to enroll in the VFC program through their local health department.

State supplied vaccines are provided at no cost to enrolled providers through the local health department. Washington is a “universal vaccine distribution” state. This means no fees can be charged to patients for the vaccines themselves and no child should be denied state supplied vaccines for inability to pay an administration fee or office visit.

Molina follows HCA Medicaid Provider Guides for reimbursing a provider’s administration costs. Providers must bill state-supplied vaccines with the

appropriate procedure codes and a SL Modifier for identification and reporting purposes. More specific information regarding billing for state-supplied vaccines can be found on the Physician Related Services/Health Care Professional Services Provider Guide at: hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

Prenatal Care

Stage of Pregnancy	How often to see the doctor
First Visit	As soon as member knows they are pregnant
1 month - 6 months	1 visit a month
7 months - 8 months	2 visits a month
9 months	1 visit a week
Postpartum	7 to 84 days after delivery
Note: More visits may be needed if recommended by provider or if pregnancy is considered to be high risk for complications.	

Emergency Services

Emergency Services means: Inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition.

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

Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 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 howto handle routine health problems at home.
- Avoid making non-emergent visits to the emergency room (ER).

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer

back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Virtual Urgent Care

To enable members to access care after hours and when lack of transportation or child care resources inhibit their ability to see their provider, Molina offers Virtual Urgent Care 24/7. Learn more at: https://www.molinahealthcare.com/members/wa/en-us/hp/medicaid/imc/covered/virtual-care.aspx

Health Management Programs

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

Telehealth and Telemedicine Services

Molina Members may obtain physical and behavioral health Covered Services by Participating Providers, through the use of 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.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services 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 additional information on Telehealth and Telemedicine Claims and billing, please refer to the **Claims and Compensation** section of this Provider Manual.

7. 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 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 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 Review
  - Referrals for Discharge Planning and Care Transitions
  - Staff education on consistent application of UM functions
- **Quality Management**
  - Satisfaction evaluation of the UM program using Member and Provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - Quality oversight
  - Monitor for adherence to CMS, NCQA, State and health plan UM standards

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 or contact the UM department.

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

UM Decisions

A decision is any determination 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 or 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 (800) 869-7175 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 a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the Enrollee that endanger life, cause suffering of pain or result in an illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the Enrollee requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

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

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

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

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

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in 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 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 (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 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 PA 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 PA 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 PA, refer to the PA code Look-Up 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 administrative review followed by 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, pharmacy director or appropriately licensed health professional).

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

Clinical Information

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

- Providers are encouraged to use the Molina Prior Authorization Form provided on the Molina web site. If using a different form, the prior authorization request must include the following information:
- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, 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 (include treatment, diagnostic tests, examination data).
- Requested length of stay (for inpatient requests).
- Rationale for expedited processing.

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

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 the 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.

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 (800)869-7185.

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

The Peer-to-Peer and Reconsideration Process

In the case of adverse determination, the requesting provider has the option to submit a reconsideration request or schedule a Peer-to-Peer discussion with a medical director, within the time frames listed below, in order to avoid the appeals process. Pursuing these options is appropriate when there is additional information or context not provided in the clinical information that may result in an approval.

Peer-to-Peer

- May be requested within **5 business days** from adverse benefit determination (denial) notification (written or fax notification) or at any time during an inpatient admission;

- May not be requested if a formal appeal has been filed;
- May not be requested when no clinical information was submitted and the denial was based on lack of information. In this case, please follow the Reconsideration pathway. Submitting clinical information with a Reconsideration request may result in an approval or a revised denial that would come with new Peer-to-Peer and Reconsideration timeframes;
- Time period to request a **Peer-to-Peer: 5 business days**.

Reconsideration by the Utilization Management Department

- May be requested within **14 calendar days** from adverse benefit determination (denial) notification (written or fax notification);
- May be requested if new clinical information is available that was not previously submitted at the time of the initial denial determination;
- May be requested if no clinical information was submitted and the denial was based on lack of information;
- May be requested following discharge from an inpatient level of care;
- May be requested if provider is unable to request a Peer-to-Peer discussion within 3 business days after the adverse benefit determination (denial) notification;
- Reconsideration cannot be requested following a Peer-to-Peer discussion. In this case, please follow appeal pathway for further dispute rights;
- Time period to request a **Reconsideration: 14 calendar days**.

Scheduling a Peer-to-Peer

Please call (425) 398-2603 to request and schedule a Peer-to-Peer discussion or if you have questions regarding the Peer-to-Peer or Reconsideration process.

Peer-to-Peer discussions will be scheduled Monday through Friday from 9 a.m. to 4 p.m. PST, excluding holidays. For Advance Imaging (AI) authorizations, please call (855) 714-2415 (enter 92 for WA). A Molina Medical Director will call you at your scheduled date and time, at the direct number provided.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires 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

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. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

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

You can click on the following link to take you to the login page: onehealthport.com

Fax: Please use the Molina PA request form found on our website at: Frequently Used Forms I Molina Healthcare of Washington Be sure to send the form to the attention of the Healthcare Services Department and include along with your request the supporting documentation needed for Molina to facilitate an expeditious turnaround.

Molina Healthcare:

Medical/Behavioral Health:	(800) 767-7188
Advanced Imaging:	(877) 731-7218
Inpatient Census:	(800) 413-3806
NICU:	(800) 767-7188
Transplant:	(877) 813-1206

Kaiser Foundation Health Plan of the Northwest: (877) 800-5456

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at: (855) 322-4082 or Kaiser Foundation Health Plan of the Northwest: (800) 813-2000 for Kaiser patients. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of Washington
Attn: Healthcare Services Dept.
PO Box 4004
Bothell, WA 98041-4004

Open Communication about Treatment

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

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

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (800) 869-7175 during normal business hours, Monday through Friday (except for holidays) from 8 a.m. to 5p.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 24 hours a day, seven days a week at (888) 275-8750 (English) and (866) 648-3537 (Spanish). Molina's Nurse Advice Line may handle after-hours UM calls.

Emergency Services

Emergency Services means: a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary

services routinely available to the emergency department to evaluate that Emergency Medical Condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

Emergency Medical Condition or Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) 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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency Care for Behavioral Health Condition means services provided for an individual, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability.

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

Emergency Services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Molina also provides Members 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 24-hour Emergency Services for ambulance and hospitals. An out-of-network emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member will be responsible for payment.

Molina covers maintenance care and post-stabilization services which are medically necessary, non-emergency services. Molina or its delegated entity arranges for post-stabilization services to ensure that the patient remains stabilized from the time the treating hospital requests authorization until the time the patient is discharged or a contracting medical provider agrees to other arrangements.

Pre-approval of emergency services is not required. Molina requires the hospital emergency room to contact the Member's Primary Care Provider (PCP) upon the Member's arrival at the emergency room. After stabilization of the Member, Molina requires pre-approval of further post-stabilization services by a participating Provider or other Molina representative

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 inpatient admissions and procedures to any facility. Facilities are required to also notify Molina within 24 hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 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 review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within 24 hours of the request.

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

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

Inpatient Status Determinations

Molina's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements (refer to the **Medical Necessity** section 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 review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Molina conducts retrospective (post claims) provider preventable readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates. If it is determined that the subsequent admission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions. Readmission to the same acute facility within 14 days of the initial or index admission will be subject to clinical reviews if the readmission is determined to be related to the previous admission. (WAC 182-550-2950)

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:

- Readmission for reasons unrelated to conditions or care from index or initial admission.
- Repetitive treatments such as cancer chemotherapy or other required treatments for cancer, transfusions for chronic anemia, burn therapy, dialysis or other planned treatments for renal failure.
- Planned therapeutic or procedural admission following diagnostic admissions when the therapeutic treatment clinically could not occur during the same case.
- Same day planned admission to a different hospital unit for continuing care and can include mental health/substance use disorder transfers and rehabilitation transfers which may be technically coded as discharge/admission for billing reasons.
- Required treatments for cancer including treatment related toxicities or care for advanced stage cancer.
- End of life and hospice care.
- Patients who left Against Medical Advice (AMA) from index or initial admission.
- Readmission due to patient non-adherence to the discharge plan, despite appropriate discharge planning. This also includes cases where the recommended discharge plan was refused by the patient and a less appropriate alternative plan was made to accommodate patient preferences; this must be clearly documented in the record.
- Obstetrical readmission for birth after an antepartum admission.
- Admissions with a primary diagnosis of mental health and substance use disorder issue.

- Transplant readmissions within 180 days of transplantation.
- Neonatal readmissions.
- Readmissions when the index admission occurred in a different hospital system.

Effective January 15, 2022: As Molina Healthcare performs admission reviews, if a readmission to the same hospital/same diagnosis within 24 hours after leaving against medical advice is noted, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay. A single payment will be considered as payment in full for both the first and second hospital admissions

Administrative Days

Hospitals requesting authorization of administrative days must submit a separate authorization request from the inpatient hospital stay. All hospitals are entitled to bill administrative days including for Mental Health, LTAC, Physical Medicine and Rehabilitation. Administrative days are intended for Mental Health services in a community hospital only and not available for service provided in an Evaluation/ Treatment Center.

Hospital facilities have up to 14 calendar days to request an administrative day rate from the date of the expiration of the inpatient authorization the notice of adverse benefit determination for continued stay authorization or the exhaustion of the appeal process, whichever is later. All requests received beyond the established timeframes will be escalated to a supervisor for review of extenuating circumstance.

Molina requires the following information be included in the request for authorization:

- Current clinical data
- Submission of documented discharge/placement efforts
- Documentation of phone call and fax responses regarding placement to include specific information of contacted providers
- Documentation of specific rationale for declines related to placement
- Plan of care including specific needs and long-term goals

If the Member's condition is such that custodial care is appropriate, the Provider/Facility will be directed to Home Community Services (HCS) for Long Term Care (LTC) for future placement needs. If the Member's diagnosis includes Chemical Dependency issues the Provider will be asked to refer the Member for possible Substance Use Disorder (SUD) treatment.

Authorization process for Mental Health follows the HCA Provider Billing Guide for Mental Health.

Acute administrative days will require Prior Authorization (Admin Day template/rev code 0191/0169) and may be authorized subject to the following:

- The member has a legal status of "voluntary."
- The member no longer meets Medical Necessity criteria.
- The member no longer meets Intensity of Service criteria.
- Less restrictive alternatives are not available, posing a barrier to safe discharge.
- The hospital and Molina mutually agree to the appropriateness of the administrative day.

Administrative days must be billed on a separate claim form:

- For acute care stay paid under DRG - revenue code 0191 must be billed on the claim for administrative days and the acute care stay claim must be billed with inpatient status code 30 to indicate a separate claim will be submitted for administrative days
- For per-diem - paid services bill with revenue code 0169

Newborn Administrative Days

Facilities may request up to 5 days of an inpatient hospital stay for the postpartum parent following the parent's medical discharge when the newborn remains as an inpatient on a hospital claim at the facility. "Postpartum parent" is defined as the client who carried the pregnancy and has delivered the baby(ies). The newborn administrative day rate is payable if the inpatient hospital days meet all the following criteria:

1) **Newborn:** The newborn was exposed in útero to a substance or substances that may lead to physiologic dependence and continuous care by the postpartum parent is the appropriate first-line treatment (i.e., "Eat, Sleep, Console" or other non-pharmacologic similar model defined by continuous care by the birth parent).
2) **Postpartum parent:** The postpartum parent is able to room in with the newborn and provide continuous support and care. The additional inpatient hospital days on the newborn administrative day rate are for the postpartum parent.
3) **Medication:** The billing provides all prescribed medications to the postpartum parent for the duration of the stay, including medications prescribed to treat substance use disorder. These should be billed as a separate line item from the inpatient pharmacy, per WAC 182-550-4550.
4) **Additional Services:** The billing hospital provides at least the following services to the postpartum parent while inpatient under this newborn administrative day rate: a hospital bed/rooming in with the newborn, nutritional support for the parent and other services depending on the newborn's needs (e.g. lactation support, nursing assessment and intervention, rounding, discharge planning)

Billing for 5 Allowable Newborn Administrative Days

To receive payment the hospital must bill newborn administrative days with revenue code 0191 with ICD 10 diagnosis code 099.320 (drug use complicating pregnancy) on the postpartum parent's Provider One ID. Pharmaceuticals prescribed for the client's use during the administrative portion of their stay must be billed, and will be paid, on a claim separate from that of the acute care stay. For the acute care stay claim, the provider must bill with inpatient status code 30 to indicate the provider will be submitting a separate claim for newborn administrative days and include a claim note that states "Admin, days claim to follow."

Additional Monitoring Days Prior to Discharge

Facilities may request additional newborn administrative days (i.e., beyond day five) if the days meet the newborn, postpartum parent, medication and additional services criteria specified in the previous section, and the following additional criteria are met:

1) The newborn requires ongoing monitoring and does not meet criteria for discharge as they are having difficulty with one or more of the following:
    a. Feeding or sucking or poor weight gain;
    b. Gastrointestinal disturbance (e.g., vomiting, diarrhea, cramping);
    c. Sleep (i.e., falling asleep or maintaining sleep); or
    d. Being consoled (e.g., excessive crying or irritability, tremors, hypertonia).
2) The newborn must be able to receive continuous care from postpartum parent:
    a. Newborn has not transferred into the Neonatal Intensive Care Unit (NICU) or the Pediatric Specialty Unit for closer monitoring.
    b. The postpartum parent is staying at the hospital to provide continuous care.

Hospital facilities have up to 14 calendar days from the birth parent's discharge to request the first five (5) newborn administrative days. If requesting additional newborn administrative days [i.e., beyond day five (5)], the facility has 14 calendar days from the last covered newborn administrative day to make the request. All requests received beyond the established timeframes will be escalated to a supervisor for review of extenuating circumstances.

Molina requires the following information be included in the request for authorization:

- Current clinical data

Post Service Review

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

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

Affirmative Statement About Incentives

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

Molina requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and service and 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 in order to provide medical care to Molina Members. Molina requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

Avoiding Conflict of Interest

The HCS department affirms its decision-making is based on 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 under-utilization. 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 Integrated Care Management (ICM) 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 identification of resources available to the Member, such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and nan-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 course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to 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 (800) 869-7175.

Continuity and Coordination of Provider Communication

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

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 themself or unable to protect themself 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 childcare givers.
- Psychologists, social workers, family protection workers or family protection specialists.
- Attorneys, ministers or law enforcement officers.

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

Child Abuse

Washington State's toll-free, 24-hour, seven day-a-week hotline that will connect you directly to the appropriate local office to report suspected child abuse or neglect.

Hotline: 866-ENDHARM (866-363-4276)

TTY Callers: (800) 624-6186

Adult Abuse

Office of the Attorney General's Vulnerable Adult Abuse reporting line at:

(866) 363-4276 (866-END-HARM).

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

Molina will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures are 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 Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with 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 for the primary medical care of Members.

Care Manager Responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from 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 care manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the Member to determine if the Member's needs warrant care management.

- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, 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 in order to determine an appropriate time for the Member's graduation from the ICM program.

Health 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 60 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

Molina offers programs 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 via MHWCMReferrals@Molinahealthcare.com, Members can request to be enrolled or disenrolled in these programs at any time. Our Molina My Health programs include:

- Living with Asthma
- Living with Diabetes
- Living with High Blood Pressure
- Living with Heart Failure (HF)
- Living with COPD
- Living with Depression
- Weight Management
- Tobacco Cessation
- Nutrition

For more information about these programs, please call (866) 891-2320 or (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 assure 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 working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (800) 767-7188.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least once 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 evidence-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 ore eligible to serve os 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 & Provider Contact Center.

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. Referrals to specialty care outside the network require prior authorization from Molina.

Care Management (CM)

Molina provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM 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.

Molina care managers may be licensed professionals and are educated, trained and experienced in Molina's ICM program. The ICM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina care manager will assess the Member upon engagement after identification for ICM enrollment and assist with 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 ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program. The 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 Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic 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 weeks of treatment
- Member accessing emergency department services inappropriately
- Children with Special Health Care Needs

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

Phone: (800) 869-7175
Fax: (800) 767-7188

Transitions of Care

During episodes of illness involving multiple care settings, patients are at increased risk of poor health outcomes and avoidable re-admissions resulting from fragmented care if care transitions are not well executed. Molina designed its person-centered Transitions of Care (ToC) program to improve the quality of care for members with complex physical, long-term and behavioral health care needs as they transition across care settings. ToC programs have been shown to reduce preventable re-admissions, emergency department use and to improve health outcomes.

Molina defines ToC to include all services required to ensure the timely coordination and continuity of care from one care setting to another in accordance with Member's treatment progression and discharge readiness. This

includes Member's discharging from medical, psychiatric and substance use disorder (SUD) inpatient treatment facilities and others. Molina's ToC team will confirm and establish or re-establish the patient's connection to their medical home/Primary Care Physician (PCP)/Specialist and assist with the coordination of care as the patient moves from one care setting to another. The target populations for Molina's ToC program are patients that are at a high risk of re-admission, based on medical literature, predictive modeling and risk stratification tools. Identified care settings that are supported in the ToC program include but are not limited to, the following:

- Hospital/Acute Care
- Inpatient Psychiatric facilities/centers
- Long Term Acute Care
- Skilled Nursing Facility
- Rehabilitation Facility

Molina's ToC program focus is person-centered collaborative care coordination. Our Transitions team works closely with Care Management, Discharge Planners, Health Home staff, Community Health Workers, Pharmacy, providers and caregivers. This proactive collaboration helps assess for and remove barriers prior to discharge. This interdisciplinary approach ultimately results in improved health outcomes and reduced re-admissions. The ToC Team provides oversight to assure appropriate collaboration and confirms the member's identified needs have been addressed. Weekly care review meetings led by a Molina Medical Director allow for discussion and planning for complex and difficult transitions.

Molina members may be contacted by a ToC Coach via a face-to-face or telephonic visit while in the inpatient setting. The ToC Coach with the facility care team works to develop an individual care transition plan. The member will receive a call within 2 to 3 business days after discharge. The ToC Coach will assess the member's ability to make and attend all needed follow up appointments, complete medication reconciliation, nutrition management, patient's understanding of illness and how to recognize worsening symptoms, when to call their Primary Care Physician and encourage use of a health journal, assess home safety, the member's support network and community connections, and will assist the member with obtaining immediate psychosocial needs such as food, transportation, clothing, social support, advocacy and other community-based resources.

The ToC will continue to provide care coordination for up to 30 days, based on member needs and preferences. During each follow-up contact, primarily performed via telephone, the ToC Coach ensures that the goals of the Individualized Care Plan have been met and the member has successfully

transitioned to a lower level of care. As the Transitions of Care process nears completion, Molina's ToC Coach will identify any ongoing needs that a member may have and, if needed, coordinate a referral to the Molina Case Management program or Primary Care Physician who will work with the member to address those needs going forward.

Molina's standard of care for Transitions of Care includes the following and requires these elements be completed by the facilities, Primary Care Provider, Molina Contracted Staff, Care Managers or Molina Transitions of Care coach for each member as they transition between care settings.

- Assess and stratify members into levels of risk to target members at higher risk of readmission.
- Create an individual care plan to mitigate readmission to include:

Health education to support discharge care needs, for example: Medication management, ensure follow-up appointments are attended, self-management of conditions, when and how to seek medical care. Care planning is to include caregivers as needed.

- At the time of discharge, written discharge plans must be given to member, their treating providers and/or their caregiver based on member needs and preferences to ensure timely access to follow up care post discharge and identify and re-engage members who do not receive post-discharge care at time of discharge.
- Member will receive medication education and be amenable to medication regimen at time of discharge.
- Member will be provided an adequate supply of medications and/or prescriptions at discharge that will cover the days until their first prescriber appointment. Prescriptions will be sent to pharmacy of member's choosing.
- Organize post discharge services, home care services, after-treatment services and therapies, including SUD, etc.
- Telephonic reinforcement of discharge plan and needed problem solving within 2 to 3 business days from time of discharge.
- Information on what to do if a problem arises following discharge including how/when to access emergency care and crisis services.
- For patients at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition.
- Ensure members have an in-person PCP, behavioral health, Home Health or specialty provider appointment within 7 calendar days of discharge to support discharge instructions, assess environment safety, conduct medicine reconciliation, assess adequacy of support network and services and link to appropriate referrals.

- Arrange for discharge transportation and discharge aftercare appointments as needed.

In addition to the above the following are also requirements for inpatient SUD Transitions of Care:

- If the member was treated with FDA approved medications for SUD during their stay, the member will be discharged with a same day appointment for Medication Assisted Treatment (MAT) to ensure continuation of treatment.
- Provide the member with contact information for community based Peer Support and Recovery Support Services.
- Member's housing needs to be 1) Verified and documented within the electronic health record, 2) Referred to housing and community support services as needed and 3) Location of MAT services taken into consideration as applicable.

Health Home Services

Health Home implementation is authorized by Section 2703 of the federal Patient Protection and Affordable Care Act, the managed fee-for-service demonstration model and the Substitute Senate Bill 5394 from the 2011 legislative session. Under Washington State's approach, Health Homes (HH) is the bridge to integrate care within existing health delivery systems.

A Health Home is the central point for directing person-centered care for high-risk, high-cost Members in a specified geographic coverage area. The Health Home is accountable for reducing avoidable healthcare costs, specifically preventable hospital admissions/re-admissions and avoidable emergency room visits. The Health Home will provide timely post-discharge follow-up with the goal to improve Member outcomes by providing intensive care coordination services to high-cost, high-need Medicaid and Medicaid/Medicare Members to ensure that services are integrated and coordinated across medical, mental health, chemical dependency, long-term services and supports and community support services.

Molina is a qualified Health Home (AKA "lead entity") For IMC and FFS, for geographic area 1 (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties); area 2 (Island, San Juan, Skagit and Whatcom Counties); area 3 (King); area 4 (Pierce); area 5 (Clark, Klickitat, Skamania, Cowlitz and Wahkiakum); area 6 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens and Whitman Counties) and area 7 (Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin. As a qualified lead entity, Molina is responsible for providing (or contracting for) the following six specific care coordination services functions:

- Comprehensive care management

- Care coordination and health promotion
- Comprehensive transitions of care from inpatient to other settings, including appropriate follow-up
- Individual and family support, including authorized representatives
- Referral to community and social support services

As a lead entity, Molina has created integrated provider networks in the above areas to ensure physical health, mental health, chemical dependency, long term services and social support needs can be met through an integrated collaborative approach.

Molina is contracted with numerous community based Care Coordination Organizations (CCO). The CCO supports a team of care coordination staff responsible for delivery of face-to-face interactions with eligible Health Home enrollees. Molina provides direct services as a CCO and employs a state-wide network of care coordinators.

The Molina Health Home staff is a combined team of care coordinators and community health workers. The dedicated care coordination staff provide individual enrollee interactions aimed at delivering six Health Home elements of care coordination (see previous description).

The Health Care Authority determines eligibility for the members that are passively enrolled. Those determined eligible for Health Homes must have at least one chronic condition and be at-risk of a second, and have a minimum predictive risk score (PRISM) of 1.5.

Members have the ability to consent or opt-into the Health Home services, and withdraw by opting out of Health Home services.

The care coordinator will be responsible for informing and coordinating services with a Member's current medical team as needed and will support the member in receiving other community support services. When your client is receiving Health Home services you will be notified by the care coordinator by communicating the Health Action Plan to the PCP. This is an assessment and care plan that outline the member goals.

If you would like more information about Molina's Health Home program, email your questions to wahealthhomes@molinaheathcare.com

8. 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. 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 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 (800) 767-7188 or contact Molina's Prior Authorization team at (800) 869-7175.

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.

Please see the **Prior Authorization** subsection found in the **Health Care Services** section of this Provider Manual for additional information.

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 Providers to manage their health care needs. Behavioral Health Providers may identify other health concerns, including physical health concerns, that 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 provide notification to Molina 24 hours prior to discharge and have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to 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 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.

Care Management

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

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

Phone: (800) 869-7165
Fax: (800) 767-7188

Additional information on the CM program can be found in the **Care 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 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 are able to obtain needed health services within the acceptable appointment timeframes. Please see the **Quality** section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. All inpatient facilities must provide notification 24 hours 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 days of the discharge date. If a Member misses a behavioral health appointment, the Behavioral Health Provider shall contact the Member within 24 hours of a missed appointment to reschedule. Upon discharge from inpatient substance use disorder treatment, the Behavioral Health Provider must arrange transportation for all Members, as needed, to scheduled appointments and recovery-based housing.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24/7 year-round. 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 (800) 869-7175.

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, 7 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 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 Provider website at MolinaHealthcare.com.

Behavioral Health Practitioner Travel Reimbursement

Effective January 1, 2022, Medicaid Behavioral Health providers are eligible for travel reimbursement related to Mental Health Assessments for Young Children (MHAYC). Providers should use their clinical judgment and family preference when determining if travel for conducting a mental health assessment is necessary. Providers are eligible for travel reimbursement under a specific set of circumstances:

- Must be travelling to conduct a mental health assessment; and
- Must conduct a mental health assessment for a child under 6 years of age; and
- Must conduct a mental health assessment in the child/family's home or in a community setting; and
- Must use the DC:0-5 diagnostic classification system.

Providers are eligible for travel reimbursement for up to 5 sessions to administer a MHAYC, if necessary. Funds for reimbursement are available until the pool of money is depleted.

Providers must complete and submit the following forms for reimbursement:

- W9
- Molina's A-19
- Supplier Profile Form
- Molina's A-19 and Supplier Profile Form can be found at https://www.molinahealthcare.com/providers/wa/medicaid/forms/fuf.aspx

Forms and invoices must be submitted to
WA_Finance_IMC@molinahealthcare.com
Claims must be submitted prior to invoice submission. Invoices will not be paid without an adjudicated claim and invoices must be submitted no later than 60 days from supporting claim.

Molina will process and reimburse providers within 10 business days of submission.

Services provided to Wraparound Intensive Services (WISe) members are not eligible for provider travel reimbursement.

For billing information go to: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/mental-health-assessment-young-children.For additional information regarding RCW.74.09.520, go to https://app.leg.wa.gov/rcw/default.aspx?cite=74.09.520.

9. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality department toll free voicemail box at (866) 325-5173, via email at MHW_QI_Department@MolinaHealthcare.com or fax (800) 461-3234.

The address for mail requests is:

Molina Healthcare of Washington
Quality Department
P.O. Box 4004
Bothell, WA 98041-4004

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

Molina has established a Quality Improvement Program that complies with regulatory 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 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.

Patient Safety Program

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

Quality of Care

Molina has 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 and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following 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.
- Medical record content and documentation standards, including preventive health care.
- Storage maintenance and disposal processes.
- Process for archiving medical records and implementing improvement activities.

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 24 hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.

- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

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

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 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 Advance Directives, Power of Attorney and Living Will have been discussed with Member and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.

- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report.
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

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

Retrieval

- The medical record is available to Provider at each encounter.
- The medical record is available to Molina for purposes of Quality improvement.
- The medical record is available to the 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.
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with State and Federal requirements and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but never less than 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 see 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 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, 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 directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

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

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

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

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. Provider surveyed include 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 standards are based on 80 percent availability for Emergency Services and 80 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

Appointment Access

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

Medical Appointment

Appointment Types	Standard
Routine, asymptomatic	Within 30 calendar days
Routine, symptomatic	Within 10 calendar days
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 days/week availability
Specialty Care (High Volume)	Within 30 calendar days
Specialty Care (High Impact)	Within 30 calendar days
Urgent Specialty Care	Within 24 hours
Care Transitions-PCP Visit	Within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program
Care Transitions-Home Care	Transitional health care by a home care nurse or home care mental health professional or behavioral health professional within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health, if ordered by the member's PCP or as part of the discharge plan.

Behavioral Health Appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately

Non-life Threatening Emergency	Within 6 hours
Urgent Care	Within 24 hours
Initial Routine Care Visit	Within 10 business days
Follow-up Routine Care Visit (Prescriber)	Within 30 calendar days
Follow-up Routine Care (Non-Prescriber)	Within 20 calendar days

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

Office Wait Time

For scheduled appointments (including for behavioral health),the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 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.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the Molina Provider Services department toll free at (855) 322-4082 or TTY/TDD 711.

3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. If a PCP chooses to close their panel to new Members, Molina must receive 30 calendar days advance written notice from the Provider.

Women's Health Access

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

Additional information on access to care is available from your local Molina Quality department.

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 overtime, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific 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 of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

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

Physical Accessibility

Molina evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This access 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 an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies and contracts 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.

- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

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 21 years of age are timely according to required preventive guidelines. All Enrollees under 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
- Periodic objective screening for social emotional development using a recognized, standardized tool
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit

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. 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.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management and Care Management

The Molina Health Management and Care Management programs provide for the identification, assessment, stratification and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please see the Health Management and Care Management headings in the **Health Care Services** section of this Provider Manual.

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 are 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 the 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
- Recommendations for Preventive Pediatric Health Care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2022
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

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 in the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Behavioral Health 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: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

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

Effectiveness of Quality Improvement Initiatives

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

In addition to the methods described above, Molina also compiles complaint and appeals data as well as 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®/Qualified Health Plan Enrollee Experience survey Star Ratings measures, contact your local Molina Quality department.

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

Critical Incident Reporting

What is a Critical Incident?

- Critical Incidents are traumatic. When one of our members experiences a Critical Incident (CI), Molina is responsible for following up to ensure they have the care they need.
- Cis are reported to the Healthcare Authority (HCA) by Molina through semi-annual reporting as well as 24-hour notification to the HCA Incident Reporting System.
- In order to provide follow-up, it is important that our external provider network reports Cis to Molina as soon as the incident has been identified.

Critical Incident Reporting Criteria

- A major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs in a facility that provides behavioral health services and is licensed by the state of Washington to provide publicly funded behavioral health services. An unexpected death of a member that occurs in a facility that provides behavioral health services and is licensed by the state of Washington to provide publicly funded behavioral health services.
- Violent acts allegedly committed by a member to include:
    - Homicide or attempted homicide
    - Arson resulting in serious bodily harm which has the potential to cause prolonged disability or death
    - Kidnapping
    - Sexual assault
    - Abuse, neglect or exploitation of a member; not to include child abuse (APS/CPS reporting)

NOTE: The Health Care Authority has recently announced that child abuse cases are no longer required to be reported to the Medicaid MCOs such as Molina through the Critical Incident process, but rather are reported directly to the Children's Administration/CPS as part of mandatory reporting requirements. The intent is to reduce the burden of reporting and eliminate duplicative reporting as much as possible. However, if the incident also falls

under one of the additional critical incident reporting criteria outlined here, it must be reported through Molina's critical incident process.
If you have any questions, please contact us at
MHW Critical Incidents@MolinaHealthcare.com

- Death that occurred within a contracted behavioral health facility (inpatient, psychiatric, behavioral health agencies), FQHC or by independent behavioral health provider.
- Unauthorized leave from a behavioral health facility during an involuntary detention.
- Any event involving a member that has attracted or is likely to attract media attention as it relates to the criteria stated above.

What a Critical Incident is NOT:

- Threatening suicide or suicidal ideation (thinking about it)
- Routine car accidents not resulting in a serious injury
- Accidents-minor not resulting in a serious injury
- The unexpected death or serious injury of an enrollee
- A credible threat to enrollee safety
- Any allegation of financial exploitation of an enrollee

How do I report a Critical Incident?

- As soon as you are notified of the critical incident
- Ensure member safety first, then report

Some critical incidents require notification to HCA within one business day of Molina notification, so it is important that you report to Molina as soon as possible.

Molina's Critical Incident form can be found at Provider Referral Form (molinahealthcare.com). Email the completed Critical Incident form to Molina at: MHW_Critical_Incidents@MolinaHealthcare.com. If secure email is not available, you can fax the form to (800) 767-7188 "Attn: Case Management"

10. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future to treat Member who have multiple clinical conditions.

Why is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment looks at a number of clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality 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

Your Role as a Provider

As a Provider, your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as 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 CMS correct coding initiative.
- Use the correct ICD-10 code by coding 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.

Interoperability

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 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). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

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.

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 Provider does not have Direct Address, Provider, will work with its EMR vendor to set upa Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EMR does not support the Direct Protocol, 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 is appropriate 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.

Contact Information

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

11. 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 mainta|ins 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 cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

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

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

- Has actual knowledge of falsity of information in the Claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,

- Acts in reckless disregard of the truth or falsity of the information in a Claim.

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

Deficit Reduction Act

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

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of 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, that 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 form 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 of 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

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 cost 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 Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

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

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

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

event Molina identifies fraud, waste or abuse, Provider agrees to repay funds or Molina may seek recoupment.

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

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

Claim Auditing

Molina shall use established industry Claims adjudication and/or clinical practices, 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 Washington, Inc.

Attn: Compliance
PO Box 4004
Bothell, WA 98041-4004

Remember to include the following information when reporting:

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

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

Washington Health Care Authority
Attm: Office of Program Integrity
626 8th Ave SE / PO Box 45503
Olympia, WA 98504-5503

Toll Free Phone: (800) 562-6906
Fax: (360) 586-0212
Online: hca.wa.gov/about-hca/medicaid-fraud-prevention

Office of the Attorney General
Attn:Medicaid Fraud Control Division
PO Box 40114
Olympia, WA 98504
Phone: 360-586-8888
Fax: (360) 586-8888
Online: hca.wa.gov/about-hca/medicaid-fraud-prevention

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

Molina expects that its contracted Provider will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and

comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

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

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

Applicable Laws

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

1. Federal Laws and Regulations

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

2. State Medical Privacy Laws and Regulations.

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

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI

Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship and the disclosure is for the following health care operations activities:
   - Quality Improvement
   - Disease Management
   - Case Management and Care Coordination
   - Training Programs
   - Accreditation, Licensing and Credentialing

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

Confidentiality of Substance Use Disorder Patient Records

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

[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

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:

1. **Notice of Privacy Practices**

   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**

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

3. **Requests for Confidential Communications**

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

4. **Requests for Patient Access to PHI**

Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. Request to Amend PHI

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

6. Request Accounting of PHI Disclosures

Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six 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.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

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

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 30 days and should also be reported to Molina within 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

Washington State Health Care Authority Clinical Data Repository

The Health Care Authority (HCA) is advancing Washington's capabilities to collect, share, and use integrated physical and behavioral health information from provider's Electronic Health Record systems (EHRs) by implementing the Washington Link4Health Clinical Data Repository (CDR). The CDR aggregates clinical information from different EHRs in one easily accessible location. By providing access to clinical information from outside the enterprise, the CDR helps the care team gain a more comprehensive understanding of the patient's medical history. HCA has partnered with OneHealthPort to develop and manage the CDR. For more information and to learn more about the steps that need to be taken to participate in CDR please visit the Washington State Health Care Authority's CDR website, hosted by OneHealthPort, at http://www.onehealthport.com/hca-cdr. Please also review HCA's flyer for information on the CDR: Clinical Data Repository One-pager (wa.gov)
Users can complete training in one hour or less and reference materials are available on OneHealthPort's website.
Providers with certified EHRs seeing Apple Health Managed Care members must send a Consolidated Clinical Document Architecture (CODA) summary from the provider's EHR to the CDR. Behavioral health providers are encouraged to send CCDA from their EHR to the CDR. Substance use disorder providers are not required to submit CCDA to the CDR.
If you/your organization meet(s) the following criteria, you are required to participate in the CDR:

- Your organization is part of a Managed Care Organization that serves Apple Health consumers;
- Your organization has a 2014 certified EHR system; and,
- You have received monies from either the Medicare or Medicaid EHR Incentive Program

Business Continuity Plan (BCP)

The Provider will hove a documented Business Continuity Plan (BCP) to ensure 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 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.

1. Provider shall comply with the following requirements and permit Molina to audit such compliance as required by law or any enforcement agency.
2. The following terms are defined as follows:
    - I. "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.
    - II. "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 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.
    - III. "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.
    - IV. "Nonpublic Information" means information that is not publicly available information and is one of the following:
        - (a) 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;
        - (b) 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:
            - (i) social security number;

(ii) driver's license number, commercial driver's license or state identification card number;
(iii) account number, credit or debit card number;
(iv) security code, access code or password that would permit access to a Consumer's financial account; or
(v) biometric records;

(c) 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:
(i) the past, present or future physical, mental or behavioral health or condition of a Consumer or a member of the Consumer's family;
(ii) the provision of health care to a Consumer; or
(iii) payment for the provision of health care to a Consumer.

V. "State" means the State of Washington.

3. 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.
4. Provider agrees to comply with all applicable laws governing Cybersecurity Events. Molina will decide on notification to affected Consumers or government entities, except where Provider is solely responsible and required to notify such Consumers or government entities by Law. Upon Molina's prior written request, Provider agrees to assume responsibility for informing all such Consumers in accordance with applicable Law.
5. In the event of a Cybersecurity Event, 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 24 hours from a determination that a Cybersecurity Event has occurred. In addition to the foregoing, Provider shall notify Molina's Chief Information Security Officer (by telephone and email) within 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

6. Upon Provider's notification to Molina of a determination of a Cybersecurity Event, Provider must promptly provide Molina any documentation required and requested by Molina to complete an investigation, or, upon written request by Molina, Provider shall complete an investigation pursuant to the following requirements:
   (a) determine whether a Cybersecurity Event occurred;
   (b) assess the nature and scope of the Cybersecurity Event;
   (c) identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
   (d) 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.
7. 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.
8. 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 following information known to Provider at the time of the notification:
   (a) the date of the Cybersecurity Event;
   (b) a description of how the information was exposed, lost, stolen or breached, including the specific roles and responsibilities of Provider, if any;
   (c) how the Cybersecurity Event was discovered;
   (d) whether any lost, stolen or breached information has been recovered and if so, how this was done;
   (e) the identity of the source of the Cybersecurity Event;
   (f) whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
   (g) 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;

(h) the period during which the Information System was compromised by the Cybersecurity Event;

(i) the number of total Consumers in the State affected by the Cybersecurity Event;

(j) 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;

(k) a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

(l) 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; and

(m) the name of a contact person who is both familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

9. 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.

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

12. CLAIMS AND COMPENSATION

Payor ID	**38336**
Availity Essentials portal	**provider.MolinaHealthcare.com**
Clean claim Timely filling	**180 calendar days after 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 Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

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 8371 for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should 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 Services 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 Provider to Molina within 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services, unless otherwise specified in your contract. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 180 calendar days after the final determination by the primary payer of what is outlined in your provider contract. 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.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or 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.

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 30 calendar days from the change.

Per federal regulation (42.C.F.R. 455.410(b)) providers who have a contract with the state's Medicaid agency or a contract with a Managed Care Organization (MCO) that serve Medicaid Clients must enroll with HCA under a Non billing or Billing agreement. The provider's National Provider Identifier (NPI) submitted on all claims must be the NPI registered with HCA.

Molina will deny/reject all claims submitted to Molina for processing if billed with an NPI that is not enrolled with HCA or does not match what HCA identifies as the enrolled NPI number.

For additional information and to access the Non-Billing and Billing and servicing enrollment form, which must be used to register with HCA or to correct an NPI, visit the HCA website at hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider

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 under 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 (anesthesia Claims require minutes)
- 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), 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 also applies to atypical and out-of-state Providers.

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 are 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 reject.

Claim corrections submitted without the appropriate frequency code will deny 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 Washington, Inc.
PC Box 22612
Long Beach, CA 90801

Please keep the following in mind when submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PC 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 10 or 12 point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: https://www.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 24 months of the claims remittance advice date.

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.

COB

Medicaid is always the payer of last resort 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 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, 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. Molina will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

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 at:

- All states except KY – Optum: 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 by the use of evidenced-based guidelines. CMS

titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
   a) Fractures
   b) Dislocations
   c) Intracranial Injuries
   d) Crushing Injuries
   e) Burn
   f) Other Injuries
6) Manifestations of Poor Glycemic Control
   a) Hypoglycemic Coma
   b) Diabetic Ketoacidosis
   c) Non-Ketotic Hyperosmolar Coma
   d) Secondary Diabetes with Ketoacidosis
   e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
   a) Spine
   b) Neck
   c) Shoulder
   d) Elbow
11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
   a) Laparoscopic Gastric Restrictive Surgery
   b) Laparoscopic Gastric Bypass
   c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
   a) Total Knee Replacement
   b) Hip Replacement

What this means to Providers

- Acute IPPS Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing
- 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 Services representative.

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 Healthcare Common Procedure Coding System (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 resources located at https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules.

Apple Health is aware that there are instances when telemedicine is not an option and providers need to use other methods to provide care. Apple Health is temporarily allowing audio-only/telephone to be used when current practice for providing services is not an option (face to face, telemedicine). Report the service modality code (CPT or HCPC code) as you would if the encounter was in person. In these cases, Apple Health is temporarily allowing services using a telephone, as described above, to conduct an office visit. Report the code (CPT or HCPC) as you would if the encounter was in person. Always document the modality used for delivery in the health care record. Remember to: Use modifier CR. Use the PCS indicator that best describes where the client is, for example 12 is home; 31 is skilled nursing facility, 13 is assisted living facility, etc. Do not bill with the providers location as the place of service. *HCA-contracted MCOs are also adopting these policies.

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

- Service or procedure has a professional component.
- Service or procedure has a technical component.

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

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

ICD-10-CM/PCS Codes

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

Place of Service (POS) Codes

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

Type of Bill

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

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require

CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (DRG)

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

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

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 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, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

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 pay 95% of all clean claims within 30 days.

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

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. 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:

1. Submit a refund to satisfy overpayment,
2. Submit a request to offset from future claim payments or 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 made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the overpayment.

Claim Disputes/Reconsiderations/Appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the **Provider Dispute Resolution and Member Appeals** 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. Balance billing a Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval forthose services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider.
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party.
- In accordance with WAC 182-502-0160, a contracted provider may only bill fee-for-service or managed care clients for covered health care services, if the Member and the provider both sign Health Care Authority form 13-879 "Agreement to Pay for Healthcare Services" no more than 90 days prior to services being rendered. The form must be completed in full. For Members with limited English proficiency, form 13-879 must be translated into the Member's primary language. If necessary, this form must also be interpreted for the Member. If the agreement is interpreted, the interpreter must also sign it. All other requirements for form 13-879 apply.

- Providers must accept payment by Molina as payment in full in accordance with 42 CFR 447.15. Balance billing is not permitted. For additional information, refer to WAC 182-502-0160 and HCA Memo #10-25.
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
    - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
    - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.

The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud, Waste and Abuse

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

Encounter Data

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

Encounter data must be submitted at least once per month and within your contract's timely claims filing requirements in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 8371 - Institutional, 837P - Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

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

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

Molina has created 837P, 8371 and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:

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

Integrated Managed Care (IMC) Specialty Behavioral Health Providers

Behavioral Health Supplemental Transactions

As of January 1st, 2020, each mental health and/or substance use disorder provider is required to collect behavioral health supplemental transactions associated with Medicaid members assigned to Molina. Individual treatment practitioners practicing outside of a licensed behavioral health agency (BHA), including prescribers (i.e. buprenorphine providers) are the only exception to this requirement and supplemental transaction reporting is not limited to the type or level of service provided. This data is used for state and federal regulatory reporting, as well as supporting the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMS) reporting requirements.

Providers must submit data per the requirements outlined in the HCA Behavioral Health Supplemental Transaction Data Guide.

The five MCOs have retained Beacon Health Options to be the single collection point of this data for all MCO covered services provided in all regions. The only exceptions are providers of crisis services (who should submit associated supplemental data to the ASO with whom they are directly contracted for those services) and any provider who is contracted with King County Integrated Care Network (who should submit associated supplemental data directly to KC-ICN. More information on submitting this data through Beacon Health Options can be found on their website: https://wa.beaconhealthoptions.com/providers/bhsd/

Evidence/Research Based Practices

Per Washington State Legislation, HCA is required to collect information on which Evidence/Research Based Practices (E/RBP) for children under the age of 18 who are covered under Apple Health Medicaid. Providers must refer to and follow the Evidence Based Practice Institute's 2022 Reporting Guide for E/RBPs and the Service Encounter Reporting Instructions (SERI) when submitting EBP to Molina through claims or encounters. Technical assistance will be provided as needed. Molina transmits this information directly to HCA in a series of reports, per contractual requirements.

Providers are required to participate in approved E/RBPs trainings as outlined in the Evidence-Based Practice Reporting Guides or as approved by the Evidence-Based Practice Institute. For the Evidence-Based Practices

Reporting Guide and additional E/RBP information please refer to ebp-reporting-guides.pdf (wa.gov). Molina will provide additional support or assistance as needed to meet these requirements.

Rosters

The roster template has been vetted and agreed upon by all Managed Care Organizations (MCO) in Washington State. There is an "Instructions" tab for samples and explanation of each data point included in the roster.

"Roster_Template_Practitioner" tab must be completed in order for Molina's system and provider directory to be updated correctly. The "Behavioral Health" tab is not required by Molina, however may be required for other MCOs. The Roster template can be found by logging in to the Provider Portal (provider.MolinaHealthcare.com) and going to Forms tab.

Rosters need to be submitted to mhwproviderinfo@molinahealthcare.com for processing. Updates are required, at a minimum, on a quarterly basis.

Late or incorrect roster updates may result in claim denials.

Helpful hints for completing the IMC rosters:

- Include agency name in file name (e.g. "ABC BH Agency - All MCO_BH Roster Template….")
- Add/Change/Term (Column A):
  - Comments in column A should reflect the CURRENT updates for your group; remove any comments already submitted to Molina on previous rosters.
  - Changes in this column should be specific (i.e. add, term, license/degree change, location add/term, update Medicaid ID) otherwise we may not know what has changed or been updated. It is important to note the effective date of the change in the Effective Date/Termination Date column (Column B).
- Practitioner NPI (Column D):
  - Each provider on the roster must have an individual NPI in order to be loaded in our system.
- ProviderOne ID#/Medicaid ID (Column K):
  - You may submit a provider on the roster even if their ProviderOne number is pending. Please update once available.
- Degree/Title (Column L):
  - Title should be based on licensure or taxonomy, not agency specific title (e.g. Agency Affiliated Counselor- we cannot determine degree level by that title.)
  - Please be sure to list the appropriate corresponding degree level if it is not obvious by the title, to ensure the correct rates are loaded. Examples are:
    - Psychiatrist (MD/DO)

    - Nurse Practitioner (NP)
    - Physician Assistant (PA)
    - Registered Nurse (RN/ARNP)
    - License Practical Nurse (LPN)
    - Psychologists (PhD/PsyD)
    - Masters-Level Providers (CSW/LCSW/LMFT/LMHC/MA/MBA/MC/MPA/MS/MSN/MSS/MSSA/MSW)
    - Bachelors, AA or Other (BA/BAS/BS/BSW/AA)
    - Peer Counselor (HS)
    - Certified Medical Assistant (CMA)
    - Other (Clinical Staff)
    - Chemical Dependency Professional (CDP) - specify Bachelor's or Masters level if needed based on contract
    - Chemical Dependency Professional Trainee (CDPT) - specify Bachelor's or Masters level if needed based on contract
- Primary Specialty (Column V):
    - You are not limited to the specialties listed on the "Key-Specialties" tab, it is not inclusive of all IMC related behavioral health specialties.
    - Please only list one specialty in the Primary Specialty column. Additional Specialties can be listed in the Secondary Specialty column (Column AA).
- Primary Specialty Taxonomy (Column W):
    - List Federal taxonomy that is registered with HCA for each provider. We do not need the HCA specific taxonomies, with the exception of the Certified Medical Assistants (see below).
    - Certified Medical Assistant Taxonomy: there is no federally recognized taxonomy for this, so please use the HCA taxonomy (1O1Y99993L).
- Group NPI (Column AH) should be reflective of the group billing NPI, as it will appear in box 33a of claims.
- Group/Practice Name (Column AG) should be the group billing name, as it will appear in box 33 of claims.
- Location (Columns AI-AQ):
    - If a provider is practicing at multiple locations, please list each location on a separate row. Indicate which location is primary.

Obstetric Care Billing for Initial Prenatal Visit

The use of HCPCS code 0500F along with the appropriate diagnosis code is required for a member's initial prenatal visit. The 0500F code must be used along with the appropriate ICD diagnosis codes Z33.1, Z34.00, Z34.80 or Z34.90. The date a member begins receiving obstetrical care (date the OB record is initiated) is required for HCA's quality measurements, tracking and care coordination efforts.

For more information related to obstetric care and delivery billing, see HCA's Physician-related services/health care billing guide here:

https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules.

13. PROVIDER DISPUTE RESOLUTION AND MEMBER APPEALS

Member Grievances

A member has a right to file a complaint/grievance at any time about:

- The way you were treated,
- The quality of care or services you received,
- Problems getting care,
- Billing issues.

Members can file a grievance the following ways:

Mail:
Molina Healthcare
Attention: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Web: MolinaHealthcare.com

Phone: (800) 869-7165 / TTY 711

Fax: (877) 814-0342

Email: wamemberservices@MolinaHealthcare.com

Notification/Resolution of Grievances

We will let the member know we received their grievance within two business days. We will resolve the grievance within 45 calendar days and notify the member how it was resolved.

If a member has concerns about behavioral health needs, an Ombuds can help them with questions and filing grievances. Visit MolinaHealthcare.com/waombuds to see a list of regional Ombuds representatives.

Member Appeals

Members can appeal our decision if a service was denied, reduced or ended early. Here are the steps in the appeal process:

STEP 1: Molina Healthcare Appeal

STEP 2: Administrative Hearing

STEP 3: Independent Review

STEP 4: Health Care Authority (HCA) Board of Appeals Review Judge

Continuation of Services During the Appeal Process

If a member wants to keep receiving previously approved services while we review the appeal, the appeal must be filed within 10 calendar days of the date on the denial letter. If the final decision in the appeal process agrees with our decision, the member may need to pay for services they received during the appeal process.

STEP 1 – Molina Healthcare Appeal

Members have 60 calendar days after the date of Molina's denial letter to ask for an appeal. The member or their representative may request an appeal over the phone, in person or in writing. Additional information to support the appeal may be submitted over the phone, in writing or in person. Within five calendar days, we will let the member know in writing that we received the appeal.

Members can file an appeal the following ways:

Mail:
Molina Healthcare
Attention: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Web: MolinaHealthcare.com

Phone: (800) 869-7165 / TTY 711

Fax: (877) 814-0342

Email: wamemberservices@MolinaHealthcare.com

A member may choose someone, including a lawyer or provider, to represent them and act on their behalf, however they must sign a consent form allowing this person to represent them. It is the member's responsibility to cover any fees or payments to representatives.

Before or during the appeal, the member or their representative may request copies of all the documents in the appeal file and the guidelines or benefit

provisions used to make the decision, free of charge. Molina will send our decision in writing within 14 calendar days, unless we notify them we need more time. Our review will not take longer than 28 calendar days.

If the member needs an expedited decision because the member's health is at risk, call (800) 869-7165 / TTY 711 for a quick review (called "expedited" review) of the denial.

Members can file an expedited appeal either orally or in writing. Molina will contact the member with our decision within 72 hours of receiving the request for an expedited review.

If a request is made for an expedited appeal, but Molina decides the member's health is not at risk, we will follow the regular appeal timeframe. We will send a letter with the decision and a reason for the change within two calendar days of the appeal request.

The expedited timeframe may be extended up to 14 calendar days if additional information to process the appeal is needed and the delay is in your best interest. If Molina extends the timeframe, we will send a letter within two calendar days of the appeal request and a reason for the extension.

STEP 2 – Administrative Hearing

If a member disagrees with Molina's appeal decision, they can ask for an Administrative Hearing. Members must ask for a hearing within 120 calendar days of the date on the appeal decision letter. A provider may not ask for a hearing on behalf of a member. An expedited decision can be requested if the member's health is at risk.

To request an Administrative Hearing:

Contact the Office of Administrative Hearings (OAH)
Phone: (800) 583-8271
Address: PO Box 42489, Olympia, WA 98504-2489

Members may consult with a lawyer or have another person represent them at the hearing. Members can get help finding a lawyer by checking with the nearest LegalServices Office or calling the NW Justice CLEAR line at (888) 201-1014 or visit their website at nwjustice.org

If a member requests an expedited decision, a judge will make a decision within four working days after receiving the request. If the judge decides that the

member's health is not a risk, we will call and send a letter within four working days of the request. The hearing will change to the standard timeframe.

STEP 3 – Independent Review

If a member does not agree with the decision from the State Administrative Hearing, they can ask for an Independent Review within 21 calendar days of the hearing decision or go directly to Step 4. Call (800) 869-7165 / TTY 711 for help. An expedited decision can be requested if the member's health is at risk. Any extra information must be given to us within five working days of the request for the Independent Review. We will send the case to an Independent Review Organization (IRC) within three working days. Molina will notify the member of the decision.

Contact:

Molina Healthcare
Phone: (800) 869-7165 / TTY 711
Fax: (877) 814-0342
Address: PO Box 4004, Bothell, WA 98041-4004

STEP 4 – Health Care Authority (HCA) Board of Appeals

A member can ask for a final review of their case by the HCA Board of Appeals Review Judge within 21 calendar days after the IRC decision is mailed. The decision of the HCA Board of Appeals is final.

Phone: (360) 725-0910;
Toll-free: (844) 728-5212
Fax: (360) 507-9018
Address: PO Box 42700, Olympia, WA 98504-2700

Non-Covered Benefit

Exception to Rule: A member or their provider may ask Molina to approve a service that is not a covered benefit. For adults, this is called an Exception to Rule (ETR).

- It must be asked for before the member receives the service.
- To be approved, the provider must provide us with documentation that establishes that:
  - The member's condition is different from most people
  - No other covered, less costly service will meet the member's need.

- The request must meet the rules in Washington Administrative Code (WAC) 182-501-0160 for approval.

ETR decisions are final and cannot be appealed.

Note: A member can ask for an appeal at the same time a provider asks for an Exception to Rule.

Limited Benefit

Limitation Extension: Providers may ask Molina to approve more services above and beyond the regular benefits. An example is more adult physical therapy visits than the 12 visits the benefit allows. This is called a Limitation Extension (LE). To be approved, it must meet the rules in Washington Administrative Code (WAC) 182-501-0169:

- It must be asked for before the member receives more of the service.
- The member's condition must show it is improving due to the services already received.
- The member's condition must show it will likely continue to improve with more services and that it will likely worsen without continued services.

Members can ask for an appeal at the same time as a provider asks for a Limitation Extension.

Funding for some services is limited by available money: If a Member receives services that are paid for by Medicaid dollars, they have the right to appeal a decision that stops or limits those services. Some services are paid for with State-only or Federal block grant dollars. If the State-only or block grant money runs out, we cannot approve the service even if we agree the services are needed. There is no appeal process if a service is ended due to State-only or block grant money running out. We will notify members if this situation applies to them.

Provider Dispute Resolution Process

The Provider Dispute Resolution process (different from Appeals on behalf of Members) offers recourse for Providers who are dissatisfied with the payment or denial of a claim from Molina or any of its delegated medical groups/IPAs. Molina follows the Best Practice Recommendation for Extenuating Circumstances.

In the event a Provider would like to dispute a claim, the Provider may make an electronic request via the Molina Portal or fax.: (1) within 24 months of Molina's

original remittance advice date; (2) within 30 months after final determination by the primary payer. The Provider may not request payment be made any sooner than six months after Molina's receipt of the request. Any request for review of disputed claim must be submitted to Molina in accordance with the requirements stated in this section.

Molina requires submission of your dispute through one of two options:

Availity Essentials portal https://availity.com/molinahealthcare

To submit a dispute you will need to be in the Claims Status Inquiry module. Once you have identified the claim you are disputing you can click on the "Appeal Claim" button located at the bottom of the page. When you are ready to submit the dispute click on the "Submit" button.

The benefits of submitting your dispute request electronically via the Availity Essentials portal at https://availity.com/molinahealthcare include:

- The member, claim number and provider information auto populate in the form
- Electronically attach chart notes or any other documentation as part of the dispute
- Type additional information you would like included in the text box regarding your dispute request. Specify why the Provider believes the services should be compensated or adjusted If the service was denied for no prior authorization/notification you must include the extenuating circumstances as to why the prior authorization was not obtained
- In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB
- Receive an electronic acknowledgment letter immediately following submission
- Free of charge, no more postage

Fax

The Provider Dispute Resolution Request form must be completed with your request via fax.

- Complete all elements of the Dispute Resolution Request form located at MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx. Including supporting medical records and any other required documentation for review of your request. Request forms that are incomplete or missing

required information will not be reviewed and will be returned to the provider without review. Disputes submitted untimely from the original decision will be denied.
- If the dispute is regarding a claim denied for no prior authorization, you must include the extenuating circumstance as why authorization was not obtained. Extenuating Circumstances include; the inability to know member had Molina coverage, the inability to anticipate services in advance, inherent components where a service is essential to another, received misinformation from Molina and untimely authorization decision from Molina. In the case of coordination of benefits, include the name and mailing address of any entity that has disclaimed responsibility for payment including the denied EOB. Include proof of due diligence including dated eligibility confirmation from another payer, such as eligibility screen shot and/or primary payers EOB showing denied services or ineligibility of coverage.

Additional information regarding extenuating circumstances can be found under the Best Practice Recommendation for Extenuating Circumstances.

Provider Dispute Fax: Firstsource, Molina Appeals & Disputes WA, PO Box 182273, Chattanooga, TN 37422. If your claim was denied by a delegated medical group/IPA you must make your initial review request through that group. The delegated medical group/IPA addresses for dispute submission are located below. If you have a direct contract with the delegated medical group/IPA, their decision is final. All other second level reviews for providers not directly contracted with the medical group/IPA should be sent to Molina per the process above.

Molina has two levels for the dispute process. Third level dispute requests will be denied as the dispute process has been exhausted.

Request for provider disputes for medical group/IPA should be submitted to:

- Kaiser Foundation Health Plan of the Northwest:
  Kaiser Permanente NCA NW Claims
  Waterpark 1
  2500 Havana St.
  Aurora, CO 80014

The Provider will be notified of Molina's/delegated medical group IPA decision within 60 days of receipt of the provider dispute request. Providers are reminded they can NOT bill the Member when a denial for covered services is upheld.

Code Edit Policy Reconsiderations

A provider can request a reconsideration regarding a code edit policy in situations where the provider's and Molina's correct coding policy sources conflict or where they may have different interpretations of a common correct coding policy source. The Provider will be notified of Molina's decision in writing within 60 calendar days of the receipt of the Code Edit Reconsideration request, unless additional supporting documentation is required.

All requests for Code Edit Policy Reconsiderations must be submitted to Molina in writing and should include the following:

- Explanation of why the provider does not agree with Molina's current correct coding policy or interpretation. Include the supporting alternative policy information and the source where it can be found.
- Must clearly indicate "Code Edit Policy Reconsideration Request"
- Contact information for your organizations point person, i.e. name, contact number, e-mail address
- Relevant CPT/HCPCS codes or code combination examples
- Specific claim examples of denied services related to the code edit
- Must be addressed to the attention of Molina's Provider Services department

Code Edit Policy Reconsiderations do not apply to eligibility limitations, non-FDA approved services, medical policies, benefit determinations or contractual disputes. Code Edit Reconsiderations should be faxed to the Provider dispute fax number.

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.

14. 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 services representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status or patient types (e.g. Medicaid) in which the Practitioner specializes. This does not preclude Molina from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of Practitioners with whom Molina contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists

- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

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 it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – 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 never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **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 residency programs from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental

Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.

- **Fellowship Training** – If the Practitioner is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery
    - American Board of Addiction Medicine (ABAM)
    - College of Family Physicians of Canada (CFPC)
    - Royal College of Physicians and Surgeons of Canada (RCPSC)
    - Behavioral Analyst Certification Board (BACB)
    - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed 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 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 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 most recent five-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 months, the Practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one 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/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 in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. 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

[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.

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 Practitioner's 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.
- **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 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 that 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, Practitioners 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** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

Integrated Managed Care (IMC) Specialty Behavioral Health Providers

Molina credentials IMC Specialty Behavioral Health Agencies at the facility level, as they often employ lower level providers that cannot be individually credentialed (e.g. peers). The process involves completing an HDO (Health Delivery Organization) application and submitting a complete provider roster (see more information about Rosters under the **Claims and Compensation** section of this manual).

The following credentialing documents must be completed to initiate the process:

- Health Delivery Organization (HDO)* form

- Completed CMS Ownership Form with recent signature*
    - This form is waived if ALL required NPIs billed on a claim form for in-network providers are registered with HCA
- Copy of Current State License
- Copy of Most Recent CMS Survey or Accreditation Certificate
- Copy of Current Liability Insurance
- Copy of W-9
- Roster of affiliated practitioners (if applicable) (name, specialty, NPI, scope of service (PCP/Specialist)

*Credentialing documents are located in the Credentialing/Contracting section of the Frequently Used Forms section of the Molina website: MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

Please be sure to register your NPI with Health Care Authority (HCA) at hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider. This is a federal requirement in order for our plan to enroll providers. If you have questions regarding this requirement, please direct them to HCA at (800) 562-3022 ext. 16137.

Molina credentials IMC Specialty Behavioral Health Agencies at the facility level, as they often employ lower level providers that cannot be individually credentialed (e.g. peers). The process involves completing an HDO (Health Delivery Organization) application and submitting a complete provider roster (see more information about Rosters under the **Claims and Compensation** section of this manual).

The following credentialing documents must be completed to initiate the process:

- Health Delivery Organization (HDO)* form
- Completed CMS Ownership Form with recent signature*
    - This form is waived if ALL required NPIs billed on a claim form for in-network providers are registered with HCA
- Copy of Current State License
- Copy of Most Recent CMS Survey or Accreditation Certificate
- Copy of Current Liability Insurance
- Copy of W-9
- Roster of affiliated practitioners (if applicable) (name, specialty, NPI, scope of service (PCP/Specialist)

*Credentialing documents are located in the Credentialing/Contracting section of the Frequently Used Forms section of the Molina website: MolinaHealthcare.com/providers/wa/medicaid/forms/Pages/fuf.aspx

Please be sure to register your NPI with Health Care Authority (HCA) at hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider. This is a federal requirement in order for our plan to enroll providers. If you have questions regarding this requirement, please direct them to HCA at (800) 562-3022 ext. 16137.

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Molina will notify the Practitioner immediately if credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification 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 10 calendar days of receiving notification from Molina.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Practitioner's response must be sent to Molina Healthcare, Inc., Attention: Credentialing Director, at PC 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 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 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 working days. Molina will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Notification of Credentialing Decisions

Molina will make a determination to approve or deny a credentialing application no later than 90 days after receiving a complete application from a Practitioner.

A letter is sent to every Practitioner with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within 15 calendar days of the decision. Copies of the letters are filed in the Practitioner's credentials files.

Recredentialing

Molina recredentials every Practitioner at least every 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 Practitioners when occurrences of poor quality are identified. If a Molina Practitioner is found to be sanctioned or excluded, the Practitioner's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

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

15. DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization Management
2. Credentialing and Recredentialing
3. Claims
4. Complex Case Management
5. CMS Preclusion List Monitoring
6. 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.

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

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

For a quick reference, the following table reflects the Claims and Referral/Authorization contact information for all medical groups/IPAs currently delegated for Claims payment and/or UM functions for the Medicaid lines of business.

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
Kaiser Foundation Health Plan of the Northwest	KPNW	IMC-AH (IMC Apple Health) IMC-AHA (IMC Apple Health Adult) IMC-BD (IMC Apple Health Blind Disabled) IMC-PREM (IMC Apple Health w Premium)	Physical Health Services only: Waterpark 1 2500 Havana St Aurora, CO 80014 Behavioral Health Services including Mental Health and Substance use disorder: Molina Healthcare PC Box 22612	For Physical Health Services KPNW: Phone: (800) 813-2000 Fax: (877) 800-5456 For Behavioral Health Services including Mental Health and Substance use disorder Molina Healthcare: Phone: (800) 869-7185 Fax: (800) 767-7188

IPA / CAP Group Name	ID Card Acronym	CAP Lines of Business	Claims Remit to Address	Referral / Authorization Information
			Long Beach, Ca 90801	
Kaiser Foundation Health Plan of the Northwest	KPNW	AHPREM (Apple Health with Premium) AHFAM (Apple Health Family/Pregnancy Medical) AHA (Apple Health Adult) AHBD (Apple Health Blind Disabled)	Physical Health Services and Behavioral Health Services: Waterpark 1 2500 Havana St Aurora, CO 80014	Physical Health Services KPNW: Phone: (800) 813-2000 Fax: (877) 800-5456

NOTE: The Member's Molina Healthcare ID card will identify the group the Member is assigned to by the acronyms listed above. If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group's remit address and phone number for prior authorizations.

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 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.

Delegation Criteria

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

Care Management

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

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

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

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

Organizations delegated for CM may have additional reports required to assist Molina Healthcare in fulfilling its oversight responsibilities.

Claims Administration

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

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

Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

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

Organizations delegated for Claims and/or Encounters may have additional reports required to assist Molina Healthcare in fulfilling its oversight responsibilities.

Credentialing

Credentialing functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions. To be delegated for credentialing functions, Medical Groups, IPAs, and/or Vendors must:

- Pass Molina's credentialing pre-assessment.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG, SAM, Washington State Department of Health, News Releases and published state Medicaid exclusion and termination lists a minimum of every 30 calendar days.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against Centers for Medicare & Medicaid Services (CMS) Medicare Opt-Out Affidavits List a minimum of every 30 calendar days.
- Have a process for monitoring adverse events at least every six months
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every 30 calendar days after hire.
- Correct deficiencies within mutually agreed upon timeframes when issues of non- compliance are identified by Molina
- Agree to Molina's contract terms and conditions for credentialing delegates

- Submit timely and complete Credentialing delegation reports using the current version of the Standardized Delegate Roster Template which is also detailed in the Delegated Services Agreement to the applicable Molina contract
- Comply with all applicable federal and state laws
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members
- Enroll all practitioners National Provider Identifier (NPI) into Washington State ProviderOne and revalidate once every 5 years
- Submit a copy of current NCQA certification or accreditation document.

If the Medical Group, IPA or Vendor sub-delegates Credentialing functions, the sub- delegate must be NCQA accredited or certified in Credentialing functions or demonstrate and ability to meet all Health Plan, NCQA, and state and federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and at least annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

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

Organizations delegated for Credentialing may have additional reports required to assist Molina Healthcare in fulfilling its oversight responsibilities.

Utilization Management (UM)

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

- Have an UM program that has been operational at least one (1) year prior to delegation and includes an annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina's UM pre-assessment, which is based on NCQA, state and federal UM standards, and Molina Policies and Procedures.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Ensure that only licensed physicians/dentists/pharmacists make medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every 30 calendar days after hire.
- Agree to Molina's contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Agreement to the applicable Molina contact.
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA.
- Comply with all applicable federal and state laws.

Molina does not allow UM delegates to further sub-delegate UM activities.

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

Organizations delegated for UM may have additional reports required to assist Molina Healthcare in fulfilling its oversight responsibilities

Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider Organizations. Molina will include all network Providers, including those in Medical Groups, IPAs or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider

Organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA or Vendor's Quality Improvement Program.

Capitation Models

Molina Healthcare employs a variety of Capitation reimbursement models; only organizations or individuals with a significant number of Members to spread the financial risk are approved for capitation contracts.

Primary Care Capitation: An individual PCP or a group of PCPs receive a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare.

Full Risk/Global Capitation: IPA or PHO receives a monthly prepaid amount from Molina Healthcare as compensation for a contractually defined set of services, which are designated as capitated by Molina Healthcare. These services are typically global in nature (i.e., these groups have assumed financial responsibility for all covered health care services unless specifically carved out by Molina Healthcare). Financial responsibility for all services (including carve outs) is defined in the financial responsibility matrix attached to the full risk/global Capitation agreement.

Financial Viability of Capitated Organizations

Molina Healthcare is obligated to monitor the financial status of the groups to whom it has given financial risk. This is a contractual and business responsibility. We use all reasonable methods to prevent placing an organization at risk for more than they are able to manage. We work to ensure there is little risk to any Providers who would look to the organization for payment of Claims. Prior to the initial contracting under a capitation model with an organization, Molina Healthcare assesses the organization's financial condition by reviewing the two most recent years audited financial statements and year-to-date unaudited financial statements for the current year.

Physician Incentive Plan (PIP)

Every year, Molina Healthcare is required to submit a report to HCA disclosing incentive terms for all Provider contracts. For Providers/Provider groups with substantial financial risk (any organization that could be adversely or positively

affected financially by the referral volume of its Members), Molina Healthcare is required to disclose additional documentation.

Organizations with substantial financial risk must provide information to Molina Healthcare including:

- Mode of payments to Providers and any payment plans considered to be PIPs
- Evidence of stop-loss protection
- Evidence of annual Member satisfaction surveys

Reporting Requirements of Organizations

Once contracted, Molina Healthcare expects all organizations, identified as bearing substantial financial risk on the PIP, to submit the following documents to Molina Healthcare:

Complete quarterly financial statements including:

- Balance Sheet
- Income Statement
- Statement of Cash Flows
- Audited annual financial statements

Organizations delegated for Claims may have additional reports required to assist Molina Healthcare in fulfilling its financial oversight responsibilities.

Capitation Operations

Joint Operations Committee Meetings: Molina Healthcare is available to meet as needed to address operational or contractual issues. On a quarterly basis, Molina Healthcare tries to meet with each of its organizations that operate under a capitation model. The purpose of the meetings is to:

- Identify any operational difficulties between the organization and Molina Healthcare and determine plans for a remedy
- Educate one another on changes to either the organization or Molina Healthcare
- Provide an opportunity for staff to meet their counterparts in order to facilitate more productive interactions

The meetings are facilitated by the Provider Services Representative but include any other Molina Healthcare staff who may be pertinent to issues at hand.

Funds Flow Document: Because the contract is a lengthy and somewhat complicated document, Molina Healthcare works with the capitated organization to write a Funds Flow document outlining:

- Payment rates
- Mode of payment
- Division of financial responsibility
- Any special payment arrangements

The purpose of this document is to provide all involved staff at the organization and Molina Healthcare with a guide for adhering to the terms of the contract.

Encounter Reporting

Each capitated organization delegated for Claims payment is required to submit encounter data for all adjudicated Claims. The data is used for many purposes, such as reporting to the Medicaid Statistical Information System (MSIS), Apple Health rate setting and risk adjustment,

HCA's hospital rate setting, the quality improvement program and Healthcare Effectiveness Data and Information Set (HEDIS®) reporting.

The encounter data reporting specifications can be found at MolinaHealthcare.com/providers/wa/medicaid/PDF/MHW-Introduction-to-Claims-and-Encounters.pdf.

16. 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) and Washington State Drug Utilization Review (DUR) Board meet quarterly to review and recommend medications for formulary consideration. The P&T Committee and Washington State DUR Board are organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and

necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee voting membership consists of external physicians and pharmacists from various clinical specialties

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. 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 (855) 322-4082.

Drug Formulary

Molina keeps a list of drugs, devices and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription and over-the-counter products Members can get from a pharmacy. Some medications require prior authorization (PA) 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 PA 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

Nonformulary 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 PA form which is available on the Molina website at MolinaHealthcare.eom/~/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/prior-auth-pharmacy.pdf. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of a 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, PA must be obtained through the standard PA process.

New-to-Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six months on the market. During this period, access to these medications will be considered through the PA 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 PA request forms; the following information MUST be included for the request form to be considered complete.

- Member first name, last name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication PA Request form to Molina at (800) 869-7791. A blank Medication PA Request Form may be obtained by accessing https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/prior-auth-pharmacy.pdf or by calling (855) 322-4082.

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.

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.

If it is determined to be a Pharmacy benefit, Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations representative with any further questions about the program.

Newly FDA approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Molina completes Utilization Management for certain Healthcare Administered Drugs. 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 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 opioids and pain safety as needed.

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

On November 1st, 2017, the HCA implemented an opioid policy. The policy limits the number of pills prescribed for short-term use:

- For children age 20 or younger: 18 doses

(1 tablet or 1 capsule or 1 suppository or 5 ml_ of a liquid)

- For adults age 21 or older: 42 doses

In addition, the HCA added a limit of 120MME per day on 11/1/19. For more information, see the HCA Opioid webpage at hca.wa.gov/billers-providers-partners/programs-and-services/opioids.

Prescription Drug Monitoring Program

Beginning October 1, 2021, all states will require Medicaid providers to check the prescription drug monitoring program (PMP) before prescribing and shortly after dispensing a controlled substance (Schedule II through Schedule V) to a Medicaid client.