

PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Iowa, Inc.

(Molina Healthcare or Molina)

Health Link, Health and Wellness & Hawki

Medicaid, LTSS, and CHIP

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. A printed copy of this manual is available to Network Providers upon request without cost.

Last Updated: 5/1/2023



Hawki
Iowa HHS



Iowa Health Link
IOWA HHS



TABLE OF CONTENTS

1.	CONTACT INFORMATION	2
2.	PROVIDER RESPONSIBILITIES	6
3.	CULTURAL COMPETENCY AND LINGUISTIC SERVICES	16
4.	MEMBER RIGHTS AND RESPONSIBILITIES	21
5.	ELIGIBILITY, ENROLLMENT, DISENROLLMENT	22
6.	BENEFITS AND COVERED SERVICES	25
7.	HEALTH CARE SERVICES.....	41
8.	BEHAVIORAL HEALTH	62
9.	QUALITY	66
10.	RISK ADJUSTMENT MANAGEMENT PROGRAM	83
11.	COMPLIANCE.....	85
12.	CLAIMS AND COMPENSATION	104
13.	COMPLAINTS, GRIEVANCES, AND APPEALS PROCESS	121
14.	CREDENTIALING AND RECREDENTIALING	126
15.	DELEGATION.....	136
16.	PHARMACY	138
17.	MANAGED LONG-TERM SERVICES AND SUPPORT (MLTSS).....	142

1. CONTACT INFORMATION

Molina Healthcare of Iowa, Inc.
500 SW 7th St. Suite 304
Des Moines, IA 50309

Phone: (844) 236-1464

Iowa Department of Health and Human Services
Iowa Medicaid
1305 E Walnut St.
Des Moines, IA 50319

Phone: (855) 889-7985

Certain functions that are centralized for the organization may be handled in centralized cities outside of Iowa. All centralized teams work in concert with the Molina Healthcare of Iowa, Inc. teams for final decisions.

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.

Phone: (844) 236-1464

Fax: (833) 671-3988

Availity Essentials portal: provider.MolinaHealthcare.com

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 (PCP), and Member complaints. Member Services representatives are available 7:30 a.m. – 6 p.m. CT, Monday through Friday, excluding State holidays. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.

Phone: (844) 236-0894

TTY/TDD: 711

Claims Department

Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Availity Essentials portal) whenever possible. Molina's gateway clearinghouse, SSI (formerly Claimsnet), is contracted with hundreds of clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

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

To verify the status of your Claims, please use the Availity Essentials portal. For other Claims questions contact Provider Services.

Claims Recovery Department

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

Claims Recovery correspondence mailing address:

Molina Healthcare of Iowa, Inc.
Claims Recovery Department
PO Box 2470
Spokane, WA 99210-2470

Phone: (866) 642-8999

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 or 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

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: (844) 236-2096

TTY/TDD: 711 Relay

Health Care Services Department

The Health Care Services (HCS) department delivers utilization management (UM) and care management (CM) services to Molina Members. UM conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. CM works with Members to address health related issues, gaps in care, coordination of care, education to Members and others. 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 Authorization/Service Request 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

Phone: (844) 236-1464

Prior Authorization Fax: (319) 774-1295

Pharmacy Prior Authorization Fax: (877) 733-3195

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 (BH). For Member behavioral health needs, please contact us directly at (844) 236-1464.

Molina has partnered with Your Life Iowa, the state-wide Crisis Line that supports BH, Substance Use Disorder (SUD), gambling, and other mental needs and may be accessed by Members 24/7 year-round by contacting 988. The Your Life Iowa 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 for Members experiencing psychological distress. Providers should offer this information to all Members with behavioral health conditions. In Iowa, Your Life Iowa & 988 is also the State's National Suicide Lifeline Contractor available to anyone who needs behavioral health support, not just Molina Members.

Pharmacy Department

A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina at (844) 236-1464.

Quality Improvement

Molina maintains a Quality Improvement department to work with Members and Providers in administering Molina's Quality Programs.

Phone: (844) 236-1464

Molina Healthcare of Iowa, Inc. Service Area

Molina Healthcare of Iowa offers Medicaid and Hawki/CHIP coverage in all counties in Iowa.

2. PROVIDER RESPONSIBILITIES

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination of 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](https://www.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 Molina 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 a minimum, 30 calendar days in advance of any changes in 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 expressed in the Provider Agreement.

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

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

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

National Plan and Provider Enumeration System (NPES) Data Verification

CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPES) data.

NPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPES 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 NPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

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

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

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

Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Availity Essentials portal within 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](https://MolinaHealthcare.com) 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 requires 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 MLNIA.

Molina's gateway clearinghouse is SSI (formerly Claimsnet) is contracted with hundreds of clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse. 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 required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Molina 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@echohealthinc.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 Iowa 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 MLNIA.

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 a Member's ID card and 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
- Access Member care plans

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 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 in this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and 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 telephone IVR system at (844) 236-1464

Providers can also verify Medicaid eligibility directly with the state through the Eligibility and Verification information System (ELVS):

- Access the ELVS web portal at <https://connect.edissweb.com>
- Call ELVS: (800) 338-7752 (toll free) or (515) 323-9639 (locally in Des Moines)

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

Member Cost Share

Providers should verify the Molina Member's cost share, such as Client Participation and copay, status prior to requiring the Member to pay a copay or other cost sharing that may be applicable to the Member's specific benefit plan.

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, 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.

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 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.

Pharmacy Program

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

Participation in Quality Programs

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

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

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

Compliance

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

In compliance with 42 CFR 455.104(c)(1)(iv) Providers must notify Molina within 35 calendar days after any change in ownership of the disclosing entity. Such notifications should be made by emailing Molina at: IAProviderContracting@MolinaHealthcare.com.

Confidentiality of Member Health Information and HIPAA Transactions

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

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or 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.

For additional information please refer to the Complaints, Grievances and Appeals Process 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

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. This includes participation in HHS efforts to promote cultural competency. 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 persons with disabilities, low income, or lack of homes, 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](https://www.molinahealthcare.com), from your local Provider Services representative and by calling Molina Provider Services at (844) 236-1464.

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 can be found in the Member Handbook located at <https://www.molinahealthcare.com/members/ia/en-us/mem/medicaid/member-materials-and-forms.aspx>.

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 in the Member Handbook located at <https://www.molinahealthcare.com/members/ia/en-us/mem/medicaid/member-materials-and-forms.aspx>.
4. If a Molina Member is in need of language assistance services while at your office and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency (LEP). You can find resources on meeting your LEP obligations at <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: ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Form: hhs.gov/ocr/complaints/index.html
--	--

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

Cultural Competency

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

Provider and Community Training

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

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

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

Integrated Quality Improvement – Ensuring Access

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

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

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

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (844) 236-0894. 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 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 Molina 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: (844) 236-2096 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 preventive services.

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 link:

<https://www.molinahealthcare.com/members/ia/en-us/mem/medicaid/quality/rights.aspx>.

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

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

For additional information, please contact Molina at (844) 236-0894, 7:30 a.m. – 6 p.m. CT. 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.

5. ELIGIBILITY, ENROLLMENT, DISENROLLMENT

Enrollment

Enrollment in Medicaid Programs

The Iowa Department of Health and Human Services (HHS) makes enrollment and disenrollment decisions.

Molina Healthcare of Iowa (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all Members without regard to race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. This includes gender identity, pregnancy, and sex stereotyping.

Eligibility Verification

Medicaid, LTSS and CHIP Programs

The State of Iowa, through HHS, determines eligibility for the Health Link (Medicaid and LTSS) and Hawki (CHIP) Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Medicaid, LTSS and Hawki (CHIP) Programs

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

- Availity Essentials portal at provider.MolinaHealthcare.com
- Molina Provider Services automated IVR system at (844) 236-1464
- Iowa Medicaid Provider Access Portal (IMPA) through the Member Look-up Tool: <https://secureapp.dhs.state.ia.us/imp/default.aspx>
- Medicaid Eligibility can also be verified through HHS by accessing the Eligibility and Verification Information System (ELVS):
 - Calling (800) 338-7752
 - ELVS portal—for more information: <https://dhs.iowa.gov/ime/providers/tools-trainings-and-services/provider-tools/ELVS>

Possession of a Molina ID Card does not mean a recipient is eligible for Medicaid or CHIP services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed

care plan. The name and telephone number of the managed care plan are given along with other eligibility information.

Identification Cards

Molina Sample Member ID Card

 	Member Numbers Member Services: (844) 236-0894 TTY: 711 24/7 Nurse Advice/24/7 Línea de Consejos de Enfermeras: (844) 236-2096 National Suicide & Crisis Lifeline/Línea Nacional de Suicidio y Crisis: 988 Cost Shares are a summary only. Visit MyMolina.com for plan details.	Provider Numbers CVS Caremark Help desk: (800) 349-0679 Prior authorization/notification of hospital admission: (844) 236-1464 Medical Claims: Molina Healthcare of Iowa, Inc. PO BOX 93153 Long Beach, CA 90809-9994 Inpatient admissions: Provider to notify plan within 24 hours of admission.
Medicaid Name/Nombre: <Member First Name> <Last Name> Member ID#: <XXXXXXXXXX> DOB: <MM/DD/YYYY> Effective/Fecha efectiva: <MM/DD/YYYY> Bring your Molina ID card when you see your doctor or go to receive care. Lleve su tarjeta de identificación de Molina cuando vea a su médico o vaya a recibir atención. If you have an emergency, call 911 or visit the nearest emergency room (ER). For non-emergencies, call your PCP or the 24/7 Nurse Advice Line. Si tiene una emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Si no está seguro de si necesita ir a la sala de emergencia, llame a su PCP o la línea de consejo de enfermería de atiende 24/7. HMO Molina Healthcare of Iowa, Inc.	Member Numbers Member Services: (844) 236-0894 TTY: 711 24/7 Nurse Advice/24/7 Línea de Consejos de Enfermeras: (844) 236-2096 National Suicide & Crisis Lifeline/Línea Nacional de Suicidio y Crisis: 988 Cost Shares are a summary only. Visit MyMolina.com for plan details.	Provider Numbers CVS Caremark Help desk: (800) 349-0679 Prior authorization/notification of hospital admission: (844) 236-1464 Medical Claims: Molina Healthcare of Iowa, Inc. PO BOX 93153 Long Beach, CA 90809-9994 Inpatient admissions: Provider to notify plan within 24 hours of admission.

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

Disenrollment

Enrolled Members have the right to disenroll from Molina as follows:

- For cause, at any time.
- Without cause 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later.

- Without cause at least once every 12 months.
- Without cause upon reenrollment if a temporary loss of enrollment has caused the Member to miss the annual Disenrollment period.

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

The state will make decisions regarding disenrollment. The effective date of an approved disenrollment will be no later than the first day of the second month following the month in which the Member requests disenrollment (if voluntary) or Molina refers the request to HHS (if involuntary).

Member Disenrollment Requests

A Member, or Member's representative, may request to disenroll from Molina orally or in writing. The Member must seek resolution through Molina's Grievance process before a determination will be made on a disenrollment request. If, at the conclusions of the Grievance process, the Member is dissatisfied with the outcome, Molina will direct the Member to contact HHS to request disenrollment. HHS will make the final disenrollment determination.

PCP Assignment

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

PCP Changes

Members may change their PCP at any time. Members who wish to change their PCP may call Molina Member Services at (844) 236-0894. Members may also manage their health care any time via the Member Portal available at MyMolina.com. Members may use the Member Portal to change their PCP, update their contact information, request a new ID card and view service history.

6. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Health Link, Health and Wellness and Hawki Members. 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 Availity Essentials portal. You may also contact Molina at (844) 236-1464, 7:30 a.m. – 6 p.m. CT.

Member Cost Share

Cost Share such as Client Participation and copays is the amount that Members must pay for Covered Services provided under their Molina plan. The Cost Share amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card.

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

Providers should verify the Molina Member's Cost Share status prior to requiring the Member to pay a Copay, 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).

State-Covered Services

Some services are carved out and covered by the State's fee-for-service (FFS) or other State programs instead of Molina. These include:

- Dental Services provided outside of a hospital setting
- Money Follows the Person (MFP) grant services
- School-based services provided by the Area Education Agencies, Local Education Agencies and Infant & Toddler Providers

For details on how and where to access these services, Members can call the Iowa Medicaid Member Services Unit toll-free at (800) 338-8366, Monday through Friday from 8 a.m. to 5 p.m.

Service Covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located on the Molina website and the Availity Essentials portal.

Molina Healthcare of Iowa covers, at a minimum, benefits and services in alignment with Fee-for Service (FFS) services covered under the Iowa Medicaid program specified in our agreement with the State of Iowa Department of Health and Human Services. Molina also may cover additional Value-Added Services. Please see the Availity Essentials portal for the most up-to-date covered service information. Certain services may require Prior Authorization.

The below chart outlines coverage of certain covered services, but it may not be all encompassing.

*The Iowa Health and Wellness Plan (IHAWP) column denotes coverage for a Member who has not been deemed medically exempt. An IHAWP Member who has been determined by the Department to be medically exempt shall be given the choice of receiving the benefits and service delivery method provided by the IHAWP plan or receiving benefits and services pursuant to Medicaid.

	Medicaid	Iowa Health and Wellness Plan (IHAWP)*	Hawki
Preventative Services			
Affordable Care Act (ACA) preventive services	Covered	Covered	Covered
Routine check-ups	Covered	Covered; limitations may apply	Covered
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Covered up to age 21	Covered up to age 21	Not covered
Immunizations	Covered	Covered; limitations may apply	Covered
Preventative Services			
Primary care Provider	Covered	Covered	Covered
Office visit	Covered	Covered	Covered
Allergy testing	Covered	Covered	Covered
Allergy serum and injections	Covered	Covered	Covered
Certified nurse midwife services	Covered	Covered	Covered

Chiropractor	Covered; limitations may apply	Covered; limitations may apply	Covered; limitations may apply
Contraceptive devices	Covered	Covered	Covered
Dentists or routine dental exam	Covered	Covered	Covered (though another plan due to carve out)
Diabetic self-management training	Covered; once per Member, lifetime maximum	Covered; 10 hours of outpatient self-management training within a 12-month period plus follow-up training of up to 2 hours annually	Covered
Family planning and family planning related services	Covered	Covered	Covered
Gynecological exam	Covered	Covered; limited to one visit per year	Covered
Injections	Covered; limitations may apply	Covered; limitations may apply	Covered; limitations may apply
Laboratory tests	Covered	Covered	Covered
Newborn child - office visits	Covered	Covered	Covered
Podiatry	Covered; routine foot care is not covered unless it is part of a Member's overall treatment related to certain health care conditions.	Covered; routine foot care is not covered unless it is part of a Member's overall treatment related to certain health care conditions.	Covered
Routine eye exam - <i>One routine vision exam per calendar year.</i>	Covered	Covered	Covered
Routine hearing exam <i>One routine hearing exam per calendar year.</i>	Covered	Covered	Covered
Specialist office visit	Covered; PCP referral may be required	Covered; PCP referral may be required	Covered; PCP referral may be required

Hospital Services			
Inpatient Hospital Admissions			
Preapproval of inpatient admissions	Required for non-emergent admissions	Required for non-emergent admissions	Required for non-emergent admissions
Inpatient Hospital Services			
Room and board	Covered	Covered	Covered
Inpatient physician services	Covered; includes anesthesia	Covered; includes anesthesia	Covered
Inpatient supplies	Covered	Covered	Covered
Inpatient surgery	Covered	Covered	Covered
Bariatric surgery for morbid obesity	Covered	Not covered	Covered; limitations may apply
Breast reconstruction, following breast cancer and mastectomy	Covered	Covered	Covered; limitations may apply
Organ/bone marrow transplants	Covered; limitations apply	Covered; limitations apply	Covered; limitations apply
Outpatient Hospital Services			
Abortions	Certain circumstances must apply	Certain circumstances must apply	Covered; certain circumstances must apply
Ambulatory surgical center	Covered; includes anesthesia	Covered; includes anesthesia	Covered; includes anesthesia
Chemotherapy	Covered	Covered	Covered
Dental treatment that cannot be completed in a normal office setting	Covered	Covered	Covered
Dialysis	Covered	Covered	Covered
Outpatient diagnostic lab, radiology	Covered	Covered	Covered
Emergency Care			
Ambulance	Covered	Covered	Covered

Urgent care center	Covered	Covered	Covered; may require prior authorization
Hospital emergency room	Covered; copay per visit may apply for non-emergent medical services	Covered; copay per visit may apply for non-emergent medical services	Covered; copay per visit may apply for non-emergent medical services if the family pays a premium for the Hawki program
Non-Emergency Medical Transportation (NEMT)	Covered	Not covered - covered only for Enrolled Members determined Medically Exempt	Not covered
Behavioral Health Services			
Assertive Community Treatment (ACT)	Covered	Not covered unless Member has been determined to be Medically Exempt	Not covered
Behavioral Health Intervention Services (BHIS), including applied behavior analysis	Covered	Covered; Residential treatment is not covered unless Member has been determined to be Medically Exempt	Not covered
(b)(3) services (intensive psychiatric rehabilitation, community support services, peer support, and residential substance use treatment)	Covered (MCO Members only)	Not covered unless Member has been determined to be Medically Exempt	Not covered
Inpatient mental health and substance abuse treatment	Covered	Covered; Residential treatment is not covered unless Member has been determined to be Medically Exempt	Covered
Office visit	Covered	Covered	Covered
Outpatient mental health and substance abuse	Covered	Covered	Covered

Psychiatric Medical Institutions for Children (PMIC)	Covered	Covered for ages 19 to 20; limitations may apply	Not covered
Outpatient Therapy Services			
Cardiac rehabilitation	Covered	Covered	Covered
Occupational therapy	Covered	Limited to 60 visits per year	Covered
Oxygen therapy	Covered	Limited to 60 visits in a 12-month period	Covered
Physical therapy	Covered	Limited to 60 visits per year	Covered
Pulmonary therapy	Covered	Limited to 60 visits per year	Covered
Respiratory therapy	Covered	Limited to 60 visits per year	Covered
Speech therapy	Covered	Limited to 60 visits per year	Covered
Radiology Services			
Mammography	Covered	Covered	Covered
Routine radiology screening and diagnostic services	Covered	Covered	Covered
Sleep study testing	Covered	Covered	Covered
Laboratory Services			
Colorectal cancer	Covered	Covered	Covered
Diagnostic genetic testing	Covered	Covered	Covered
Pap smears	Covered	Covered	Covered
Pathology tests	Covered	Covered	Covered
Routine laboratory screening and diagnostic services	Covered	Covered	Covered

Sexually Transmitted Infection (STI) and Sexually Transmitted Disease (STD) testing	Covered	Covered	Covered
Durable Medical Equipment (DME)			
Medical equipment and supplies	Covered	Covered	Covered
Diabetes equipment and supplies	Covered	Covered; limitations may apply	Covered
Eyeglasses	Covered; limitations may apply	Covered for ages 19 to 20; limitations may apply	Covered; limitations may apply
Hearing aids	Covered	Covered for ages 19 to 20; limitations may apply	Covered; limitations may apply
Orthotics	Covered; limitations may apply	Not covered	Covered; limitations may apply and Prior authorization required
Sleep apnea device	Covered for adults	Covered	Not covered
Long-Term Services Supports (LTSS) – Community-Based			
Case management	Covered for individuals with a developmental disability and HCBS Waiver populations only	Not covered	Not covered
Child care medical services	Covered	Not covered unless Member has been determined to be Medically Exempt	Not covered
Private duty nursing/Personal cares per EPSDT authority	Covered up to age 21 under EPSDT	Covered up to age 21 under EPSDT	Not covered
Section 1915(C) Home- and Community-Based	Covered	Not covered	Not covered

Section 1915(l) Habilitation Services	Covered	Not covered unless Member has been determined to be Medically Exempt	Not covered
- Home Health Services: Home health aid - Skilled nursing - Therapies (PT/OT/Speech)	Covered	Covered	Covered
Long Term Services and Support (LTSS) – Institutional			
ICF/ID (Intermediate Care Facility for Individuals with Intellectual Disabilities)	Covered; limitations apply	Not covered	Not covered
Nursing Facility (NF) and Nursing Facility for the Mentally Ill (NF/MI)	Covered; limitations apply	Not covered unless Member has been determined to be Medically Exempt	Not covered
Skilled Nursing Facilities (SNF)	Covered; limitations apply	Covered; limitations apply Limited to 120-day stays	Not covered
Special Population Skilled Nursing Facility Out of State (Skilled preapproval)	Covered; limitations apply	Not covered	Not covered
Hospice			
Daily categories: - Routine care If Member is residing in a Nursing Facility, room and board charges covered at 95% - Facility respite - Inpatient hospital - Continuous	Covered	Covered; limitations apply Respite: Limited to fifteen (15) Days per lifetime for inpatient respite care. Fifteen (15) Days per lifetime for outpatient hospice respite care. Hospice respite care must be used in increments of not more than five (5) Days at a time.	Covered
Health Homes			

Chronic Condition Health Homes	Covered	Not covered unless Member has been determined to be Medically Exempt	Not covered
Integrated Health Homes	Covered	Not covered unless Member has been determined to be Medically Exempt	Not covered

You may also contact Molina at (844) 236-1464, 7:30 a.m. – 6 p.m. CT.

Obtaining Access to Certain Covered Services

Non-Preferred Drug Exception Request Process

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

- For a Standard Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within 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 HHS.
- 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.
- Molina will allow a seven-day emergency supply for certain mental health drugs deemed to have a significant variation in therapeutic or side effects profile from other drugs in the same therapeutic class per Iowa Medicaid PDL requirements. See the Preferred Drug list at www.iowamedicaidpdl.com for designated medications.

Specialty Drug, Injectable and Infusion Services

Many specialty drugs or self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a specialty pharmacy. More information about our Prior Authorization process, including a link to the PA request form, is available in the Pharmacy and Health Care Services section of this Provider

Manual. Physician Administered drugs require the appropriate full NDC be submitted on the Claim.

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

Access to Behavioral Health Services

Members may receive Covered Services from an in-network behavioral health Provider without a referral. Molina's Nurse Advice Line is available 24 hours a day, 7 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 above or by contacting Molina. If residential services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation.

Emergency Mental Health or Substance Abuse Services

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

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

Out-of-Area Emergencies

Members having a behavioral health emergency who cannot get to a Molina-approved 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.

Emergency Transportation

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

Non-Emergency Medical Transportation

Molina Members who have non-emergency medical transportation (NEMT) as a Covered Service (as outlined in the tables above) must contact Access2Care at (866) 849-2062 at least 48 hours in advance to schedule transportation. Examples of non-emergency medical transportation include, but are not limited to, ride sharing, mass transit, litter vans and wheelchair accessible vans. Members must have Prior Authorization from Molina for ground and air ambulance services before the services are given. Prior Authorization is not required for vans, taxi, etc. Additional information regarding the availability of this benefit is available by contacting Provider Services at (844) 236-1464.

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/ia/medicaid/health/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.

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](https://www.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. Molina does not require prior authorization or PCP referral for the provision of EPSDT services. The standards and periodicity schedule generally follow the recommendations from the AAP (American Academy of Pediatrics) and Bright Futures.

The screening services include:

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

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

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

Prenatal Care

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

Emergency Services and Urgent Care Services

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

- Furnished by a Provider that is qualified to furnish these services under Title XIX of the Social Security Act.
- Needed to evaluate or stabilize an Emergency Medical Condition.

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

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

Urgent care means: those services rendered for an urgent medical condition or the protection of the public health.

Urgent medical condition means: a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, would reasonably expect the illness or injury to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in jeopardy
- Impairment to bodily functions, or
- Dysfunction of any bodily organ or part.

Emergent and urgent care Services are covered by Molina without an authorization. Screening and examination services conducted to determine if an Emergency Medical Condition exists are also covered by Molina. This includes non-contracted Providers inside or outside of Molina's service area. Emergency services are available 24 hours per day, 7 days per week. Molina will process and adjudicate claims for non-contracted/non-Iowa Medicaid enrolled providers at the amount that would have been paid if the service had been provided under Iowa's fee for service Medicaid program.

Consideration for Emergency Medical Services:

Molina Healthcare of Iowa wants to ensure that each member has access to timely and appropriate care for emergency related conditions. To this end, the Molina Healthcare of Iowa will not:

- Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms
- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCO, or applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.

- Members will not be held liable for payment of subsequent screening and treatment need to diagnose the specific condition or stabilize the member.

The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Molina Healthcare of Iowa

Post-Stabilization

In accordance with emergency services treatment, Molina Healthcare of Iowa is financially responsible for post stabilization care services obtained within or outside Molina Healthcare of Iowa that are pre-approved by one of our plan providers or Molina Healthcare of Iowa representative. Molina limits charges to members for post stabilization services to an amount no greater than what we would charge the member if services were obtained through Molina.

Molina Healthcare of Iowa is financially responsible for post stabilization care services obtained within or outside Molina that are not pre-approved by a plan provider or other Molina representative but administered to maintain the member's stabilized condition within one (1) hour of a request to Molina for pre-approval of further post stabilization care services.

Molina is financially responsible for post stabilization care services obtained within or outside Molina that are not pre-approved by a plan provider or a Molina representative, but administered to maintain, improve or resolve the member's stabilized condition if:

- a. Molina Healthcare of Iowa doesn't respond to a request for pre-approval within one(1) hour
- b. Molina Healthcare of Iowa cannot be contacted
- c. Molina Healthcare of Iowa representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, Molina Healthcare of Iowa must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one(1) of the criteria in 42 CFR 422.113(c)(3) is met.

Non-emergency Use of Emergency Room (ER)

In accordance with state requirements, there is an \$8 copayment for Iowa Health and Wellness Plan Enrolled Members' non-emergency use of an ER and a \$25 copayment for Hawki Enrolled Members' non-emergency use of an ER. A copayment shall not be imposed on Hawki Enrolled Members whose family income is less than 181% of the federal poverty level or Iowa Health and Wellness Plan Enrolled Members whose family income is at or below 50% of the federal poverty level.

To impose cost-sharing for non-emergency use of the ER, the hospital providing the care must first conduct an appropriate medical screening pursuant to 42 C.F.R. § 489.24 to determine the individual does not need Emergency Services.

Before providing non-emergency treatment and imposing cost-sharing for such services on an individual, the hospital must:

- Inform the individual of the amount of their cost-sharing obligation for non-Emergency Services provided in the emergency department;
- Provide the individual with the name and location of an available and accessible alternative non-Emergency Services Provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed;
- Determine that the alternative Provider can provide services to the individual in a timely manner with the imposition of a lesser cost-sharing amount. The assessment of Access to timely services shall be based on the medical needs of the Enrolled Member; and
- Provide a referral to coordinate scheduling for treatment by the alternative Provider.

Nurse Advice Line

Members may call the Nurse Advice Line at (844) 236-2096 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 Molina Members:

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

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

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.
- Member cost sharing may apply based on the applicable benefit guide found in the Member Handbook.
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Provider must comply with applicable Federal and State guidelines for telehealth service delivery.

For 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 process.
- Ensuring that UM decision making tools are appropriately applied in determining any medical necessity decision.

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) & 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
 - 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 defines adverse benefit determination (ABD) as:

- The denial or limited authorization of a required service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claims does not meet the definition of a “Clean Claim” is not an ABD.
- The failure to provide services in a timely manner, as defined by HHS.
- The failure of Molina to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals
- The denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Molina follows a hierarchy of medical necessity decision making with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

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

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

Providers can contact Molina’s Healthcare Services department at (844) 236-1464 to obtain Molina’s UM Criteria.

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

Medical Necessity

“Medically Necessary Services” or **“Medical Necessity”** means those Covered Services that are, under the terms and conditions of the Contract, determined through Molina UM to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the enrolled Member;
- Provided for the diagnosis or direct care and treatment of the condition of enrolled Member enabling the Enrolled Member to make reasonable progress in treatment;

- Within standards of professional practice and given at the appropriate time and in the appropriate setting;
- Not primarily for the convenience of the enrolled Member, the enrolled Member's physician or other Provider; and
- The most appropriate level of Covered Services, which can safely be provided.

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 for Cite 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 prior authorization (PA) request and sending it directly to Molina, health care Providers may 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, PET scans. To see the full list of imaging codes that require PA, refer to the PA code LookUp Tool at MolinaHealthcare.com.

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Molina review process begins with 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 lead to an adverse medical necessity 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 consider such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specific services in compliance with federal and 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](https://www.molinahealthcare.com). Molina will notify Providers 30 calendar days in advance of any new services which would require prior authorization.

Providers are encouraged to use the Availity Essentials portal to submit authorization requests electronically. The standard prior authorization form is also provided on the Molina web site for submission by fax. All prior authorization requests must include the following information:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
 - Pertinent medical history (including treatment, diagnostic tests, examination data).
 - Requested length of stay (for inpatient requests).
 - Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from 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 follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborn Mothers Health Protection Act.

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

For an expedited organization determination/pre-service authorization request where a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health, Molina will make a determination as promptly as the Member's health requires and no later than 72 hours after we receive the initial request for

service. For a standard authorization request, Molina makes the determination and provides notification no later than 14 calendar days from the receipt of complete request. For post stabilization requests, the Provider must indicate the request is for a post stabilization review, and must contact the UM nurse line at (844) 236-1464 during normal business hours and the nurse advice line at (844) 236-2096 during evening, weekend, holiday hours. Post stabilization requests will be responded to within one (1) hour. Post stabilization care services are covered services, related to an emergency medical condition that are provided after a Member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Member's condition.

Providers who request prior authorization approval for patient services and/or procedures may schedule to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (844) 236-1464.

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.

Peer-to-Peer Review

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

A "peer" is considered a physician, physician assistant, or nurse practitioner, who is directly providing care to the Member. Contracted external parties, administrators, or facility UM staff can request that a peer-to-peer telephone communication be arranged and performed.

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

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

If a Medical Director is not immediately available, the call will be returned within two business days. Every effort will be made to return calls as expeditiously as possible.

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
- Prior Authorization Code Matrix
- Prior Authorization Guide

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

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

Fax: The Prior Authorization Request Form can be faxed to Molina at: (319) 774-1295.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at (844) 236-1464. It may be necessary to submit additional documentation before the authorization can be processed.

Open Communication about Treatment

Molina prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with, and act as an advocate for their patients. Molina requires provisions within Provider contracts that prohibit 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 and perform the delegated activities and maintain specific

delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (844) 236-1464 during normal business hours, Monday through Friday (except for holidays) from 8:00 a.m. - 5:00p.m. All staff Members identify themselves by providing their first name, job title, and organization.

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

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

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, seven days a week at (844) 236-2096. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Emergency Services

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

- Furnished by a Provider that is qualified to furnish these services under Title XIX of the Social Security Act.
- Needed to evaluate or stabilize an Emergency Medical Condition.

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

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

See: 42 C.F.R. § 438.114(a).

Urgent care means: those services rendered for an urgent medical condition or the protection of the public health.

Urgent medical condition means: a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, would reasonably expect the illness or injury to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in jeopardy
- Impairment to bodily functions, or
- Dysfunction of any bodily organ or part.

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

Emergency Services are covered on a 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 may not be covered and the Member may be responsible for payment.

Members over-utilizing the emergency department will be contacted by Molina Care Managers to provide assistance whenever possible to 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 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 the clinical documentation needed 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, Molina retains responsibility until discharge, or for 60 days after disenrollment, whichever occurs first. Molina will notify the facility of the change in enrollment and coverage for financial responsibility.

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 Molina 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

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

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

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

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

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

- Transplant related readmissions.

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of 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, in which case 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. Molina will coordinate with non-network providers to ensure the cost to the member is no greater than it would be if the services were furnished within the network.

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 and utilization management vendors 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 non-duplicative.

Continuity of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to 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 (844) 236-1464.

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 themselves, or unable to protect themselves against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or child care givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

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

Child Abuse

If you believe the child is in immediate danger, call 911.

Suspected abuse or neglect of a child under the age of 18 should be reported to the Child Abuse Hotline at: (800) 362-2178.

Please be ready to provide identifying information and the whereabouts of the child. Mandatory reporters must leave a name and contact information.

Adult Abuse

If you believe an adult is in immediate danger, call 911.

If you suspect an adult is being mistreated, contact the HHS Adult Abuse Hotline at: (800) 362-2178.

If the suspected abuse is occurring in a health-related facility, contact the Iowa Department of Inspections and Appeals Nursing Home Complaint Hotline at: (877) 686-0027.

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

Molina will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze, and report aggregate information regarding abuse reporting to the 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 ICP, interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the Individualized Care Plan (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 Members, their representative and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.
- Educates Providers on their role in care coordination and collaborates on communication methods and timing.

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.

Molina offers programs to help Molina 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 the Health Education Referral Form located on MolinaHealthcare.com website. Members can request to be enrolled or dis-enrolled in these programs at any time. Our Molina My Health programs include:

- Molina My Health - Asthma
- Molina My Health - Diabetes
- Molina My Health - Hypertension
- Molina My Health - Heart Failure
- Molina My Health - COPD
- Molina My Health - Depression
- Molina My Health - Weight Management Program
- Molina My Health - Tobacco Cessation Program
- Molina My Health – Nutrition Consult Program

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

Maternity Screening and High-Risk Obstetrics

Molina offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for Members with identified high risk pregnancies to 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 (833) 616-4714 or emailed to IA_CM@MolinaHealthcare.com.

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

Program Eligibility Criteria and Referral Source

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

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

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

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the Health Management programs, including how to enroll patients and outcomes of the programs.
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Care 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 the Molina Healthcare of Iowa Health Care 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, pediatrics, and obstetrics and gynecology, as well as physician assistants and advance practice nurses are eligible to serve as PCPs. An in-network PCP shall not refuse treat a Member if they have not reached their requested panel size, which shall not exceed 1500 Members. 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. American Indian Members may choose to receive PCP services from an Indian Health Care Provider (IHCP) participating in the network as long as the Provider has capacity to provide services. 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 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

Molina provides a comprehensive Integrated Care Management (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.

The 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, 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 CM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP, and specialty Providers, such as discharge planners, ancillary Providers, the local Health Department, or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care, and social data about the Member being referred.

Members with the following conditions may qualify for 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
- Serious Mental Illness (SMI) or Substance Use Disorders (SUD)
- Intellectual or Developmental Disability (ID/DD) diagnoses
- Foster care or children engaged in the Child Welfare or Juvenile Justice System
- High-technology home care requiring more than two weeks of treatment
- Members accessing emergency department services inappropriately
- Children with Special Health Care Needs, including serious emotional disturbances (SED)

- Members utilizing long-term services and support (LTSS)
- Members who may qualify for home and community based services or who may be at risk for admission to a facility that may be avoided with home and community based services

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

Phone: (844) 236-1464

Fax: (833) 616-4714

Email: IA_CM@MolinaHealthcare.com

8. BEHAVIORAL HEALTH

Overview

Molina provides behavioral health benefits 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

Behavioral health elective inpatient and residential services (including ASAM and PMIC treatment) can be requested by submitting a Prior Authorization form or contacting Molina's Prior Authorization team at (844) 236-1464. Providers requesting after-hours authorization for these services should utilize Availity Essentials portal or fax submission options. Emergency and crisis psychiatric services do not require initial Prior Authorization, but may require concurrent review. 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. 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 receive services from an in-network behavioral health Provider without a referral, according to state service-level guidelines. 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. To determine if prior authorization is required for a specific service, please consult the PA Lookup Tool located on the [MolinaHealthcare.com website](https://MolinaHealthcare.com).

Behavioral health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Members may be referred to 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 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 Registered Nurses, licensed social workers or human services professionals with at least a bachelor's degree in a human services field, including sociology, special education, rehabilitation counseling and psychology 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.

Molina also offers targeted case management for Members with known or suspected Severe Mental Illness/Serious Emotional Disturbances and Substance Use/Opioid Use Disorders. Members with SMI/SED can be referred to Molina's Care Management team and will be assessed and triaged to an appropriate behavioral health Care Manager. Members with SUD/ODU concerns can be referred and may be assigned to an SUD Navigator, a Care Manager with knowledge and expertise in substance/opioid use, mental health, and pain management.

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

Email: IA_CM_Referral@MolinaHealthcare.com

Phone: (844) 236-1464

Fax: (833) 616-4714

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 chapter for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven 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.

Integrated Health Homes

Molina supports Integrated Health Homes (IHH) throughout the state of Iowa through the Learning Collaboratives, regular contact and coordination regarding shared Members. IHH agencies are designated by the state and are required to meet state criteria termed Integrated Health Home Standards. The services provided by approved IHHs are included below:

- Comprehensive care management.
- Care coordination.
- Health promotion.
- Comprehensive transitional care/follow-up.
- Patient & family support.
- Referral to community & social support services

Interested Providers should contact the Health Home Program Manager at Healthhomes@dhs.state.ia.us.

CMH Waiver and HCBS Habilitation

Molina supports the Children's Mental Health (CMH) waiver and Habilitation services according to state guidelines, see the MLTSS/HCBS section of this manual for more information on these and other LTSS services.

Behavioral Health Crisis Line

Molina has partnered with Your Life Iowa, the state-wide Crisis Line that supports BH, SUD, gambling, and other mental needs and may be accessed by Members 24/7 year-round by contacting 988. The Your Life Iowa 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 for Members experiencing psychological distress. Providers should offer this information to all Members with behavioral health Conditions. In Iowa, Your Life Iowa & 988 is also the State's National Suicide Lifeline Contractor available to anyone who needs behavioral health support, not just Molina Members.

Behavioral Health Tool Kit and Education 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 MolinaHealthcare.com Provider website.

Molina is committed to enabling behavioral health education opportunities to Providers and their staff. Through various partnerships, Molina offers CEUs and other behavioral health education at no cost to Providers. Please contact your Provider services representative for more information."

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 at (844) 236-1464.

The address for mail requests is:

Molina Healthcare of Iowa, Inc.
Attn: Quality Department
500 SW 7th ST. Suite 304
Des Moines, IA 50309

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 Molina 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 Molina 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. All Providers are required to report provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise have been made. 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. Medical record practices must be in compliance with Iowa Administrative Code 441-79.3 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 first and last name.
- Date of birth, Medicaid ID number, sex, marital status, address, employer, home and work telephone numbers, and emergency contact must be associated with Member name.
- Member's medical and social history.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care, to include first and last name and professional credentials.
- Information about services delivered by these Providers including specific procedures or treatments performed.
- The complete date of service, including the beginning and ending date if the service is rendered over more than one day.
- The complete time of service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time related services bill using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
- The location where the service was provided if otherwise required on the billing form or in Iowa Administrative Code 441—77.30(5) (c) or (d), 441-77.33(6)(d), 441—77.34(5)(d), 441—77.37(15)(d), 441—77.39(13)(e), 441—77.39(14)(d), 441—77.46(5)(i) or 441—78.9(10)(a)(1).
- Any supplies dispensed as part of the service.
- A problem list that describes the Member's medical and behavioral health conditions.

- Diagnosis of behavioral health conditions requires the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic classification system.
- Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program, as applicable.
- Presenting complaints, symptoms, and diagnoses including follow-up visits and referrals to other Providers.
- Medication administration record (MAR) including prescribed medication names, dosages, routes of administration, and dates of initial or refill prescriptions, or dispensed or administered as part of the service.
- 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 Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that are consistent with diagnosis, are person-centered and wellness-oriented, informal supports and community-based supports
- Treatment plans for Members diagnosed with behavioral health conditions must include relapse prevention, and crisis planning.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem including exam findings.
- Lab and other diagnostic tests including, but not limited to X-ray reports, that are ordered as appropriate by the Provider.
- Narrative description of any incidents or illnesses or unusual or atypical occurrence that occur during service provision.
- For 24-hour care, documentation for every shift of the services provided.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- The outcome of service including Member's progress in response to the services rendered, any changes in treatment, alterations of plan of care, or revision of the diagnosis.
- 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 and reports from consultants as 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 by the person providing the service.
- 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, goals or needs identified in the Member's plan of care, and physicals and operative report.
- Mileage log, including the name, date, purpose of the trip, and total miles for transportation provided as part of the service.
- 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, refer to the Compliance section of this Provider Manual

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists), and behavioral health Providers. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, seven days a week to Members. Providers must maintain hours of operation for Molina Members that are no less than the hours of operation offered to commercial patients and comparable to Medicaid fee for service hours.

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
PCP Routine and/or asymptomatic	Within 30 days
PCP, persistent symptoms	Within 48 hours
PCP, Urgent Care	Within 24 hours
PCP, Preventive Care	Within 30 calendar days
After Hours Care	24 hours/day; 7 day/week availability

Appointment Types	Standard
Specialty Care (Routine)	Within 30 calendar days
Urgent Specialty Care	Within 24 hours
Optometry Care Non-urgent	Within 3 weeks
Optometry Care Urgent	Within 48 hours
Lab and X-Ray Non-urgent	Within 3 weeks
Lab and X-Ray Urgent	Within 48 hours

Behavioral Health Appointment

Appointment Types	Standard
Life Threatening Emergency	Immediately
Non-Life-Threatening Emergency	Within 6 hours
Mobile Crisis	Within 1 hour
Urgent Care	Within 1 hour of presentation at service delivery site or within 24 hours of telephone contact request
Persistent symptoms	Seen or referred to appropriate Provider within 48 hours of reporting symptoms
Initial and/or Routine Care Visit	Within 10 business days of request and follow up within 30 calendar days
Substance Use Disorder & Pregnancy (Pregnant and in need of SUD services)	Admitted within 48 hours of seeking treatment
Intravenous drug-use	admitted not later than 14 days after request for admission, or 120 days after request if no program has capacity and interim services are made available within 48 hours

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

Office Wait Time

For scheduled appointments, 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.

Women's Health Access

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

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

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

Monitoring Access for Compliance with Standards

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

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

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.

3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of 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 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.

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.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other Member communications such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide advance directive information to the Member's family or representative and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

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

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

EPSDT Services to Enrollees Under 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)

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 Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

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

Health Management 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 approved by the Quality Improvement Committee.

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)

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

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

Preventive Health Guidelines

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

- Adult Preventive Services Recommendations
- Recommendations for Preventive Pediatric Health Care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021

- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

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](https://www.molinahealthcare.com) and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Behavioral Health 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](https://www.molinahealthcare.com).

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual

activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. 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 Molina 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).

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 Molina 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 Care 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 Molina 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). CCD 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) CCD 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 up a 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 maintains a comprehensive plan, which addresses how Molina will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste and abuse prevention, detection, and correction along with and the education of appropriate employees, vendors, Providers and associates doing business with Molina.

Molina's Special Investigation Unit (SIU) supports Compliance in its efforts to 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 Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

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

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

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

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

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

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

referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

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

What is AKB?

AKB 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 AKB 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

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

Sarbanes-Oxley Act of 2002

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

Definitions

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves 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 activities investigated by Molina include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.

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

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable Member activities 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, or otherwise unusual 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 Iowa, Inc.
Attn: Compliance
200 Oceangate Blvd. Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

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

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

Iowa Medicaid, Program Integrity Unit:

(877) 446-3787

Or

(515) 256-4615 (locally in Des Moines)

Iowa Department of Health and Human Services:

<https://dhs.iowa.gov/report-abuse-and-fraud>

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 Member's 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 Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity¹. 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

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

activities, such as preauthorization of services, concurrent review, and retrospective review of services².

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
- Care Management and Care Coordination
- Training Programs
- Accreditation, Licensing, and Credentialing

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

Confidentiality of Substance Use Disorder Patient Records

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

Inadvertent Disclosures of PHI

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

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

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 advice.

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

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

Business Continuity Plan (BCP)

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

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; an
 - (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 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

Payer ID	MLNIA
Availity Essentials portal	provider.MolinaHealthcare.com
Claim Timely filling	In-network Providers: 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. Out-of-network Providers: 365 calendar days after discharge or from the Date of Service. Coordination of Benefit/Third Party Liability: 365 days from last date of EOB from primary carrier. Corrected Claims: 365 calendar days from the last adjudication date for up to 2 years from Date of Service.

Electronic Claims Submission

Molina requires participating Providers to submit Claims electronically whenever possible, 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](https://provider.MolinaHealthcare.com)
- 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 (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.
- Access Member care plan.

Clearinghouse

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

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should 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.
- You should use the unsolicited 275 process to submit Claims attachments through your clearinghouse.

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

Please see the table at the top of this chapter for timely filing submission timelines. 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. 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. For corrected Claim submission requirements, see “Corrected Claim Process” sub-section below.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Molina will accept unsolicited 275 transactions — additional information to support a health care Claim or Encounter — through our clearinghouse. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing through a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims). For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member’s Molina ID card.

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

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.

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
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Specialty Type/Taxonomy (as applicable)
- 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), HCPCS/CPT Code and the unit of measure and quantity for all drug Claims
- 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, due to extreme circumstances, electronic Claim submission is not possible, please contact Molina at (844) 236-1464.

When submitting paper Claims:

- Paper Claim submissions are not considered to be “accepted” until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 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

Molina requires participating Providers to submit Corrected Claims electronically via EDI, or the Availity Essentials portal whenever possible. When electronic corrected Claim submission is not possible, Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

All corrected Claims:

- Original Claim number must be inserted in the applicable 837 transaction loop for submitting corrected Claims electronically, or in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim.
- 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.
- 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).

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 365 calendar days from the last adjudication date of the Claim for up to 2 years from the Date of Service.

Corrected Claims submission options:

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

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

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

Medicaid is always the payer of last resort 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:

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.

Molina will pay Claims submitted by out-of-network Providers at 80% of the Medicaid fee schedule unless the Claim is for emergency services.

Reimbursement Guidance and Payment Guidelines

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

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM.

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

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

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

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
 - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
 - In the absence of State guidance, Medicare National Coverage Determinations (NCD).
 - In the absence of State guidance, Medicare Local Coverage Determinations (LCD).
 - CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Telehealth Claims and Billing

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

- Telehealth has 3 primary types of applications which are Synchronous, Asynchronous, and Remote Patient Monitoring.
- Facilities will bill their regular codes using modifier 95.

- GT modifier is not needed for Claims processing as it is informational only.
- Originating Sites will bill Q3014 except FQHCs/RHCs will not bill this code (Q3014) as a separate service as it's part of their reimbursement process.
- Distant Sites will bill the appropriate codes with POS 02 or 10 rendered by the appropriate Provider.
- POS 02 is appropriate if Member is receiving services anywhere other than their home and POS 10 if Member is in their home.
- Both FQHCs and RHC's will bill encounter code T1015 with POS 02 and bill any other CPT codes as informational only.
- Telehealth DME delivery services are allowed.

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

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will strive to process the Claim for service within 30 calendar days after receipt of Clean Claims.

The receipt date of a Claim is the clearinghouse vendor Clean date if submitted via clearinghouse, or the date of receipt of the Clean Claim if submitted via paper.

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

In the event of an overpayment, Providers must notify Molina by contacting the Claims Recovery department and return the overpayment to Molina within 60 calendar days after the identification of overpayment. Providers should notify Molina of the reason for overpayment at:

Molina Healthcare of Iowa, Inc.
Claims Recovery Department
PO Box 2470
Spokane, WA 99210-2470

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 request to offset from future Claim payments, or
3. 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. 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

Claims payment reconsideration or Claims dispute is the initial request to investigate the outcome of a finalized Claim. First level Claim payment disputes/reconsiderations are accepted electronically and in writing within 180 days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA). Second level disputes must be submitted within 30 days from original decision date. Reconsiderations submitted after the specified timelines will be considered untimely and will be denied unless good cause can be validated.

Providers are encouraged to submit Claim disputes electronically, using the Availity Essentials portal. Alternatively, Claim disputes/reconsiderations may be submitted using the form located on the MolinaHealthcare.com website.

The item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number clearly marked on all supporting documents.

Claim reconsiderations shall be submitted at:

Availity Essentials portal: provider.MolinaHealthcare.com

Fax: (855) 275-3082

Email: lowaproviderinquiry@molinahealthcare.com

Mail: Appeals & Grievances
Molina Healthcare of Iowa, Inc
PO Box 93010
Des Moines, IA 50393

Please Note: The Provider will be notified of Molina's decision in writing within 60 calendar days of receipt of the Claims Dispute/Adjustment request.

Overpayment Disputes should be received within 90 days of overpayment notification letter date and should be mailed to:

Molina Healthcare of Iowa, Inc
PO Box 2470
Spokane, WA 99210-2470

Molina will not take any punitive actions against any Provider who files a Grievance or Claims Dispute.

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.

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.

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 created 837P, 837I, 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.

13. COMPLAINTS, GRIEVANCES, AND APPEALS PROCESS

If a Member is unhappy with anything about Molina Healthcare or its Providers, the Member should contact us as soon as possible. This includes if the Member does not agree with a decision we have made. The Member, or someone on the Member's behalf, can contact us. If the Member wants someone to speak for them, they notify Molina that a representative has been appointed. Molina can help the Member with this process by calling Member Services.

These services are free of charge. Members can call us at (844) 236-0894, TTY/TDD 711 Monday to Friday from 7:30 a.m. to 6 p.m. CT. A translator is available if a Member needs to speak in their own language and can help file their complaint, grievance, or appeal request. This service is free to all of Molina Members.

Definitions

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievance may include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the enrolled Member's rights regardless of whether remedial action is requested. Grievance includes an enrolled Member's right to dispute an extension of time proposed by Molina to make an authorization decision.

Appeal: A review by Molina of an Adverse Benefit Determination.

Provider Dispute: Provider Disputes generally encompass both grievances and appeals made by Providers. An appeal is a request to review an "action". A grievance is an expression of dissatisfaction with any aspect of Molina's operations, activities or behavioral, regardless of whether the communication requests any remedial actions. A Provider Claim Dispute is not an appeal. Molina's Provider Claim Dispute processes is detailed in the Claims and Compensation chapter of this manual under the "Claim Disputes/Reconsiderations" heading.

Adverse Benefit Determination (ABD):

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD.
- The failure to provide services in a timely manner, as defined by HHS.
- The failure of Molina to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Member Grievance Process and Timelines

Member Grievances may be filed orally or in writing. Grievances may be filed at any time. Molina will send an acknowledgement letter within 3 business days from the date of receipt as acknowledgement of receipt of the grievance. Molina's investigation and final resolution will be completed within 30 calendar days (with a possible 14 calendar day extension). A Member has the right to file a grievance if the Member disagrees with the decision to extend the timeframe.

Molina will not take any punitive actions against any Provider who represents a Member with regard to a filed Grievance.

Grievances may be submitted via the following methods:

Email: lowamemberappealsgrievances@molinahealthcare.com

Fax: (833) 832-1922

Phone: (844) 236-0894

Mail: Appeals & Grievances
Molina Healthcare of Iowa, Inc
PO Box 93010
Des Moines, IA 50393

Member Appeals Process and Timelines

Appeals may be submitted orally or in writing by Member, a Provider acting on behalf of the Member, or a Member's representative. In the event a Provider files an Appeal on the Member's behalf, the Provider must first obtain the Member's written permission. Molina will send an acknowledgement letter in 24 hours for Expedited Appeals and 3 business days for Standard Appeals from the date of receipt as acknowledgement of receipt of the appeal. Appeals must be submitted within 60 calendar days from the date on the notice of determination. Molina only offers 1 level of Appeal for Members.

Molina will not take any punitive actions against any Provider who represents a Member with regard to a filed Appeal.

Member Appeals may be submitted via the following methods:

Email: lowamemberappealsgrievances@molinahealthcare.com

Fax: (833) 832-1922

Phone: (844) 236-0894

Mail: Appeals & Grievances
Molina Healthcare of Iowa, Inc
PO Box 93010
Des Moines, IA 50393

If Molina fails to adhere to Notice and timing requirements, the Member is deemed to have exhausted Molina's Appeals process, and the Member may initiate a State Fair Hearing.

Expedited Appeals

A Molina Member, Provider acting on behalf of the Member, or Member's representative, may file an expedited appeal within 60 calendar days from the date on the notice of determination. Molina reviews the appeal, and a final determination will be made within 72 hours (with a possible 14 calendar day extension) of receipt of request for appeals meeting the definition urgent/expedited. If the Plan denies a request for an expedited resolution of an Appeal, it will transfer the Appeal to the standard timeframe of no longer than 30 calendar days from the day the Plan receives the Appeal (with a possible 14 calendar day extension) for resolution of Appeal and give the Member prompt oral notice of the denial and follow up within two Calendar days with a written notice. Members have the right to file a Grievance if the Member disagrees with the decision to extend the timeframe.

Standard Appeals Process and Timeline

A Molina Member, Provider acting on behalf of the Member, or Member's representative, may file a standard appeal within 60 calendar days from the date on the notice of determination.

Molina reviews Member appeals and provides a final determination within 30 calendar days (with a possible 14 calendar day extension) of receiving all required information. Members have the right to file a Grievance if the Member disagrees with the decision to extend the timeframe.

Continuing the Member's Benefits During the Appeal or State Fair Hearing Process:

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

- The Member's request for continuation of benefits is submitted to the Plan on or before the later of the following:

- within ten (10) Calendar Days of the Plan mailing the Notice of Adverse Benefit Determination; or, the intended effective date of the Plan's proposed Adverse Benefit Determination;
- The Member file the request for an Appeal within sixty (60) Calendar days following the date on the Adverse Benefit Determination notice;
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider;
- The original periods covered by the original authorization have not expired; and
- The Member may have to pay for those services if the denial is upheld.

Molina will provide benefits until one (1) of the following occurs:

- The Member withdraws the appeal;
- Ten (10) calendar days have passed from the date of the notice of appeal resolution and the Member have not asked for a State Fair Hearing;
- The State Fair Hearing Officer makes a State Fair Hearing decision not in the Member's favor.

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

Appeals & Grievances
Molina Healthcare of Iowa, Inc
PO Box 93010
Des Moines, IA 50393

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

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

State Fair Hearing

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

Iowa Department of Health and Human Services
Appeals Section
1305 E Walnut Street, 5th Floor
Des Moines, IA 50319

Phone: (515) 281-3094

Fax: (515) 564-4044

Email: appeals@dhs.state.ia.us

Provider Claims Dispute (Payment Reconsideration)

Claims payment reconsideration or Claims dispute is the initial request to investigate the outcome of a finalized Claim. First level Claim payment disputes/reconsiderations are accepted in electronically and writing within 180 days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA). Second level disputes must be submitted within 30 days from the decision on the original dispute. Reconsiderations submitted after the specified timelines will be considered untimely and will be denied unless good cause can be validated.

Overpayment Disputes should be received within 90 days of overpayment notification letter date.

Molina will not take any punitive actions against any Provider who files a Grievance or Claims Dispute.

Additional details on the Provider Claim dispute/reconsideration process are available in the Claims and Compensation chapter of this Provider Manual.

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.
- **Medicaid enrollment** – Provider must be enrolled with Iowa Medicaid as a Medicaid Provider. Prior to becoming a network Provider, a Provider who is a non-Medicaid enrolled Provider will be referred to Iowa Medicaid and must complete the Medicaid Provider enrollment process. The Provider is not required to see FFS recipients.
- **DEA or CDS Certificate** – Prescribing 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 will document 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 body³. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions –** Practitioners must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt-Out –** Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File –** Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List –** Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.

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.

- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioners activities on Molina's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
 - Criminal convictions, including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes.
 - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
 - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit 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, practitioner must not have any pending criminal charges in the categories listed above.

- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioners must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

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

Molina will notify the Practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the Practitioner. Examples include, but are not limited to, actions on a license, malpractice claims history, board certification actions, sanctions or exclusions. Molina is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

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

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

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Practitioner's response must be sent to Molina Healthcare, Inc., Attention: Credentialing Director, at PO Box 2470, Spokane, WA 99210

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

If the Practitioner does not respond within 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 and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within one business day of the decision. Notification of recredentialing approvals are not required.

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

- The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- State Medicaid Exclusions – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- Medicare Exclusion Database (MED) – Molina monitors for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- Medicare Preclusion List – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- National Practitioner Database – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- System for Award Management (SAM) – Monitor for 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 and Fair Hearing Rights

In cases where the Credentialing Committee recommends an adverse action, such as suspension or termination of a Practitioner's contract based on quality of care or professional conduct, a notification is sent to the provider by certified mail. The notice shall:

- State the reasons for action;
- Advise the Provider of their right to request a hearing on the proposed adverse action;
- Advise the Provider that any request for hearing must be made in writing within 30 days following receipt of the Notice of Action, and must be sent to the Credentialing Committee Chair by certified mail, return receipt requested, or personal delivery;

- Advise the Provider of their right to be represented by an attorney or another person of their choice;
- Advise the Provider that the request for a hearing must be accompanied by a check in the amount of \$1000.00 as a deposit for the administrative expenses of the hearing and specify this amount will be refunded if the adverse action is overturned;
- State the proposed action or recommendation, if adopted, must be reported pursuant to state and federal Law; and,
- Provide a summary of the Provider's hearing rights or attach a copy of Molina's associated policy.

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 Care 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. Any subcontracted relationship offers a seamless experience to Members and Providers. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Additionally, Molina requires delegates providing direct services to have quality improvement goals, performance improvement activities specifically to the types of services provided by the delegate and are approved by Molina. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by Molina Delegation Oversight Staff for compliance with performance expectations within the timeline indicated by Molina.

Training

Delegated entities will be expected to participate in training from the Health Plan to include but not limited to advance directives, quality of concerns, cultural sensitivity training, Fraud and Abuse and False Claims. Delegated entities providing clinical functions, like UM or complex care management, will receive training on but not limited to application of UM guidelines, assessment processes, person-centered planning and population specific training, and abuse neglect, exploitation.

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.

16. PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina Healthcare of Iowa's goal is to provide Molina 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 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 (844) 236-1464.

Drug Formulary

Molina Healthcare of Iowa keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit that are in alignment of Iowa Medicaid's Preferred Drug List (PDL). 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 and to align with the Iowa Medicaid PDL requirements.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) alerts for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-Formulary Medications

Non-formulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of manufacturer's samples of Non-Formulary or "Prior Authorization Required" medications does not override Formulary requirements.

Generic Substitution

Generic drugs should be dispensed when preferred and allowed by the Iowa Medicaid PDL. 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, experimental drugs, or those used for cosmetic purposes are not part of the benefit. Specific exclusions can be found in the formulary at [MolinaHealthcare.com](https://www.molinahealthcare.com).

Submitting a Prior Authorization Request

Molina Healthcare of Iowa 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 (877) 733-3195. A blank Medication PA Request Form may be obtained by accessing [MolinaHealthcare.com](https://www.molinahealthcare.com) or by calling (844) 236-1464.

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 and in alignment with Iowa Medicaid PDL. All reviewers will first identify Member eligibility, any Federal or State regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

Newly FDA approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Iowa Medicaid Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are

pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a Claim to Molina for reimbursement.

Molina completes Utilization Management for certain Healthcare Administered Drugs. For any drugs on the prior authorization list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require prior authorization for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the Prior Authorization list.

Pain Safety Initiative (PSI) Resources

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

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

17. MANAGED LONG-TERM SERVICES AND SUPPORT (MLTSS)

MLTSS Overview

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

Molina understands the importance of working with our Providers and partners in your area to ensure Molina Members receive MLTSS services that maintain their independence and ability to remain in the community.

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

MLTSS/HCBS Services and Molina

Long-Term Care and Support Services (LTSS) and Home and Community Base Services (HCBS) are benefits that help Members stay safe and independent in their home or community. Members can receive LTSS services if they need help with daily healthcare and living needs and meet the level of care eligibility standards.

Iowa has eight LTSS/HCBS programs:

- AIDS/HIV Waiver
- Brain Injury Waiver
- Children's Mental Health Waiver
- Elderly Waiver
- Health and Disability Waiver
- Intellectual Disability Waiver
- Physical Disability Waiver
- HCBS Habilitation Services

Waiver Program Benefits are outlined below.

AIDS/HIV Waiver

- Adult day care
- Consumer Choice Option (CCO)
- Consumer-directed attendant care (CDAC)
- Counseling services
- Home-delivered meals
- Home health aide
- Homemaker
- Nursing
- Respite

Brain Injury Waiver

- Adult day care
- Behavioral programming
- CCO
- CDAC
- Family counseling and training
- Home and vehicle modification
- Interim medical monitoring and treatment
- Personal emergency response
- Prevocational services
- Respite
- Specialized medical equipment
- Supported community living
- Supported employment
- Transportation

Children's Mental Health Waiver

- Environmental modifications and adaptive devices
- Family and community support services
- In-home family therapy
- Respite

Elderly Waiver

- Adult day care
- Assistive devices
- Assisted living
- CCO
- Chore Assistance
- CDAC

- Home and vehicle modification
- Home-delivered meals
- Home health aide
- Homemaker
- Mental health outreach
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite
- Senior companion
- Transportation

Health and Disability Waiver

- Adult day care
- CCO
- CDAC
- Counseling
- Home-delivered meals
- Home health aide
- Homemaker services
- IMMT
- Home and vehicle modification
- Nursing
- Nutritional counseling
- Personal emergency response
- Respite

Intellectual Disability Waiver

- Adult day care
- Personal emergency response
- CCO
- CDAC
- Prevocational services
- Day habilitation
- Respite services
- Home and vehicle modification
- Supported community living
- Home health aide
- Supported community living-residential based

- Interim medical monitoring and treatment
- Supported employment
- Nursing
- Transportation

Physical Disability Waiver

- CCO
- CDAC
- Home and vehicle modification
- Personal emergency response
- Specialized medical equipment
- Transportation

HCBS Habilitation Services Benefits

- Home-based habilitation
- Day habilitation
- Prevocational services
- Supported employment

Additional Managed Long-term Services and Supports:

- Community-Based Neurobehavioral Rehabilitation Services (CNRS)
- Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)
- Intermediate Care Facilities for persons with Medical Complexity (ICF/MC)
- Nursing Facility Care

Members on Long-term Services and Supports may receive:

- Intermediate care facility treatment/services
- Physician services
- Nursing services
- Dietary services
- Pharmacy services
- Behavioral management services
- Social services and activities
- Specialized rehabilitation services (including but not limited to physical therapy, speech language pathology and occupational therapy)
- Laboratory services
- Radiology and other diagnostic services
- Durable medical equipment (DME) as ordered by a physician

- Hospice, if all requirements are met

Getting Care, Getting Started

Molina care manager will engage with Members and routinely assess for barriers and opportunities to coordinate medical, behavioral health, and MLTSS services. Specifically, along with providing the Person-Centered Service Plan (PCSP), care managers provide verbal, written and/or alternate format information on:

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

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

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

- MLTSS Service Coordination
- Care and Service Plan Review
- Crisis Intervention
- Service Management
- Assessment of MLTSS Need
- Member Education

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

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

Interdisciplinary Care Team (ICT)

All MLTSS Members will receive care management and be assigned a care manager from Molina.

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

The person-centered Interdisciplinary Care Team (ICT) will include at minimum the Member and/or their authorized representative, care manager, and anyone a Member requests to participate. ICT Members may also include MLTSS Providers (e.g. *Services Facilitator, Adult Day Health Care Center staff assistive technology, transition coordinator, Nursing Facility staff, etc.*), PCP, specialist(s), behavioral health clinician, Targeted Case Management service Providers, and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required Members.

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

Community-Based Care Manager Responsibilities

The community-based 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 community-based 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 Members, their representative and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.
- Educates Providers on their role in care coordination and collaborates on communication methods and timing.

Person-Centered Service Plan Coordination

MLTSS services to be covered by Molina will require coordination and approval.

The Person-Centered Service Plan includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The PCSP includes informal care, such as family and community supports. Molina will ensure that a person-centered service plan is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301 and 42 CFR 441.725.

A Person-Centered Service Plan means the plan that documents the amount, duration, and scope of the home and community-based services. The service plan is person centered and must reflect the services and supports that are important for the Member to meet their needs, goals and preferences that are identified through an assessment of functional need. The service plan will also identify what is important with regard to the delivery of these services and supports (42 CFR 441.301 and 42 CFR 441.725).

The Person-Centered Service Plan (PCSP) will be developed under Member's direction and implemented by assigned Members of the Interdisciplinary Care Team (ICT) no later than the end date of any existing SA and within 30 days of notification by HHS of level of care or needs-based eligibility approval, or within the state specific timeframes for initial and reassessments. This applies to Members who qualify for Waiver Programs and/or HCBS Habilitation benefits. All services and changes to services must be documented in the PCSP and be under the direction of the Member in conjunction with the care manager.

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

Additional services can be requested through the Member's care manager anytime including during the assessment process and through the ICT process. Additional services needed must be at the Members direction and can be brought forward by the Member, the care manger, and/or the ICT team as necessary. Once an additional need is established, the care plan will be updated with the Member's consent and additional services approved. For additional information regarding MLTSS service coordination and approvals in the Member's ICP, please contact Molina at (844) 236-1464.

Members who reside in a Facility will receive an Individualized Care Plan (ICP). The Case Manager will work with the Facility Staff and attend Interdisciplinary Team Meetings.

Transition of Care Programs

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

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

Continuity of Care (COC) Policy and Requirements

Molina will allow for the safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing service plans, level of care, and Providers (including out-of-network Providers) until an updated service plan is completed, and either agreed upon by the Member or resolved through the Appeals or fair hearing process and implemented.

Ongoing Provider support and technical assistance will be provided especially to community behavioral health, MLTSS Providers, and out of network Providers during the continuity of care period. All existing Integrated Care Plans (ICP) and Service Authorizations (SA) will be honored during the transition period until an updated service plan is completed, and either agreed upon by the Member or resolved through the Appeals or fair hearing process and implemented.

During the first year of Molina's operations in Iowa Health Link, Molina will allow Members using an LTSS residential Provider at the time of enrollment with Molina to continue to receive care from the residential Provider being utilized at the time of enrollment for up to one year, even on an out-of-network basis. At all other times, a Member's existing Provider may be changed only in the following circumstances: (1) the Member or Member's representative requests a change; (2) the Member or their representative provides written consent to transition based on quality or other concerns raised by Molina; (3) the residential Provider has chosen not to contract with Molina; or (4) the residential Provider chooses not to serve the enrolled Member at the reimbursement rate offered.

Out-of-network Providers who are providing services to Members during the initial continuity of care period shall be contacted to provide them with information on becoming credentialed, in-network Providers. If the Provider chooses not to join the network, or the Member does not select a new in-network Provider by the time the service plan is completed, Molina will work with the Member in selecting an in-network Provider.

Members in a Nursing Facility (NF) or Intermediate Care Facility-Intellectual Disabilities (ICF/ID) at the time of Molina MLTSS enrollment may remain in that NF or ICF/ID as long as the Member

continues to meet nursing facility level of care, unless they or their family or authorized representative, prefer to move to a different NF or ICF/ID or return to the community. Members in an Intermediate Care Facility-Medical Complexity (ICF/MC) will need to meet skilled level of care in order to remain in the facility. The only reasons for which Molina may require a change in NF is if (1) Molina or HHS identify Provider performance issues that affect a Member's health or welfare; or (2) the Provider has chosen not to contract with Molina and all efforts have been exhausted to secure an alternative Provider.

Members receive initial contact from Molina within 30 days of enrollment. For additional information regarding continuity of care and transition of MLTSS Members, please contact Molina at (844) 236-1464.

Members have the choice of how their services are delivered through various models, which may include consumer-direction.

In the consumer-directed model, Consumer Choices Option (CCO) in accordance with state requirements, Molina maintains a contract with Veridian Fiscal Solutions for financial management services to assist Members who elect the CCO.

- Health and Disability Waiver
- AIDS/HIV Waiver
- Elderly Waiver
- Intellectual Disability Waiver
- Brain Injury Waiver
- Physical Disability Waiver
- Children's Mental Health Waiver

Credentialing

Molina uses a standard Credentialing and recredentialing process consistent with State required policies for MLTSS Providers. Molina also ensures that network Providers have physical access, reasonable accommodations and accessible equipment for Members with physical or mental disabilities. Detailed information about Molina's credentialing/recredentialing process is available in the Credentialing and Recredentialing section of this Provider Manual.

Appeals, Grievances, and State Hearings

Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased and appropriate resolutions. Molina MLTSS Members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process. Additional details regarding this process are available in the Complaints, Grievances, and Appeals Process chapter of this manual.

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

Provider Claims Dispute (Adjustment Request)

The processing, payment or nonpayment of a Claim by Molina shall be classified as a Provider Dispute. Information on how to file a Claim dispute is located in the Complaints, Grievances, and Appeals Process chapter of this manual.

Provider Complaints

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

Critical Incident Reporting and Management

Molina participates in efforts to prevent, detect, and remediate critical incidents, based on requirements for home and community-based waiver programs.

It is important that our Providers report any activities that seem out of the norm. It is imperative that we ensure Molina Members are protected and safe from harm. Critical incidents occur in a NF, inpatient behavioral health or home-and community-based service delivery setting (e.g., an adult day health care center, a Member's home or any other community-based setting), among other settings will be reported in a timely manner.

Major incident means: occurrence involving a Member during service provision that:

1. Results in a physical injury to or by the Member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the Member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section [232.69](#) or a report of dependent adult abuse pursuant to Iowa Code section [235B.3](#);
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a Member's location being unknown by Provider staff who are assigned protective oversight.

“Incidents” that must be reported in a timely manner include, but are not limited to:

- Abuse: The infliction (by one’s self or others) of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain or mental anguish.
 - Physical abuse is the intentional use of physical force resulting in injury, pain or impairment. It includes pushing, hitting, slapping, pinching and other ways of physically harming a person. It can also mean placing you in incorrect positions, force feeding, restraining or giving medication without your knowledge.
 - Emotional abuse occurs when a person is threatened, humiliated, intimidated or otherwise psychologically hurt. It includes the violation of your right to make decisions and/or the loss of your privacy.
 - Sexual abuse includes rape or other unwanted, nonconsensual sexual contact, but it can also mean forced or coerced nudity, exhibitionism and other non-touching sexual situations, regardless of the age of the perpetrator.
- Neglect: When someone has a duty to do so, but fails to provide goods, services, or treatment necessary to assure your health and welfare.
- Exploitation: the unlawful or improper act of using a Member or a Member's resources for monetary or personal benefit, profit, or gain.
- Misappropriation: depriving, defrauding or otherwise obtaining the money, or real or personal property (including medication) belonging to you by any means prohibited by Law.
- Death of a Member.

Reporting Procedure for Major and Critical Incidents

Identification, Report, and Referral Process when a Critical Incident is known:

- Critical Incidents may be identified through Molina Healthcare internal sources including but not limited to the Member and Provider Contact Center, Grievance and Appeals Unit, Care Management, Utilization Management, Pharmacy, Provider Services, review of Claims and encounters data, and other Molina Healthcare departments.
- Critical Incidents may be identified through external sources including but not limited to Members, Providers, community organizations, state agencies, and subcontractors.
- Staff identifying a Critical Incident completes the Critical Incident Form and sends it to the Healthcare Services, Care Management lead, Department and/or designated email box.
- HCS staff must enter every Critical Incident into Molina Healthcare’s Compliance HIPAA Management Program (CHAMP) database and/or respective state database as required within 48 hours of notification. Information in the “Critical Incident Referral Form” is entered.
- Ensure mandatory reporting is completed to appropriate external agency and notify respective designated staff (Case Manager, Service/Care Coordinator, Government Contracts, etc.) within federal and/or state mandated timeframe(s).
- Review by designated HCS staff to determine Critical Incident criteria met and investigate the case to determine next steps and resolution.

Case Investigation and Resolution:

- The designated staff member, who must be a Registered Nurse (RN) or other licensed clinical staffer, investigates Critical Incidents on a weekly basis at minimum to ensure health, safety, and welfare needs of our Members are addressed and services are in place.
- The designated staff ensures immediate action has been taken to protect the health and welfare of the Member and any other Members who may be at risk.
- The designated staff must apply contractual requirements and clinical judgement to triage and process all clinically urgent matters as expeditiously as possible.

Appropriate Follow-Up

- Molina Healthcare will follow-up within contractually required timeframe(s) to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern, which may include but is not limited to:
 - In person visits
 - Mandated reporting to Adult Protective Services (APS)/Child Protective Services (CPS) and other governmental agencies
 - Telephonic calls
- For all Critical Incidents received, Molina Healthcare will follow-up with the Member and/or the Member's representative within contractually required timeframe(s) to assure the Member's health and safety following the incident reported.
- All follow-up actions must be documented within Molina's clinical care management platform and CHAMPs database or other respective state system.
- The designated staff must apply contractual requirements and clinical judgement to determine if the reported Critical Incident is a Potential of Quality of Care (PQOC) concern.
 - In the event a Critical Incident is determined to be a PQOC, the designated staff must follow the Quality Department PQOC P&P.

Critical Incident Outcomes Tracking and/or Reporting:

- Based on federal and/or state contractual requirements and submission notification frequency, Critical Incident outcomes reports shall be sent to Iowa Medicaid.

Ongoing Monitoring:

- Internal ongoing monitoring reports may be analyzed through tracking reporting and responding to Critical Incidents to determine whether individual or systemic changes are needed.

- Reports are collected through the CHAMP, or other state required system, tracking database and analyzed by various indicators including setting, category, type, line of business, and/or waiver to assess whether any individual or global trend exist.

Record-Keeping:

- All Critical Incident documents will be kept for a minimum of ten (10) years.

Provider Reporting Procedure for Major Incidents

All Providers must report Major Incidents to Molina using the data elements in HHS Form 470-4698 <https://dhs.iowa.gov/sites/default/files/470-4698.pdf?010920231435>

When a major incident occurs or a staff member becomes aware of a major incident:

- The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
 - The staff member's supervisor.
 - The Member or the Member's legal guardian.
EXCEPTION: Notification to the Member is required only if the incident took place outside of the Provider's service provision. Notification to the guardian, if any, is always required.
 - The Member's case manager.
 - a. Once CM becomes aware of incident, CM will follow up.
 - b. If Member is not in care management, they will be assigned to a CM for follow-up.
- By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to Molina Healthcare via email at: IA_CM@molinahealthcare.com. If the Member is not enrolled with Molina, the staff member shall report the information to the department's bureau of long-term care either:
 - By direct data entry into the Iowa Medicaid Provider Access System, or
 - By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
- The following information shall be reported:
 - The name of the Member involved.
 - The date and time the incident occurred.
 - A description of the incident.

- The names of all Provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other Members or nonmembers who were present must be maintained by the use of initials or other means.
 - The action that the Provider staff took to manage the incident.
 - The resolution of or follow-up to the incident.
 - The date the report is made and the handwritten or electronic signature of the person making the report.
- Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the Provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the Member's file.

Provider Tracking and analysis.

The Provider shall track incident data and analyze trends to assess the health and safety of Members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

Fighting Fraud, Waste, and Abuse

Proper Member identification is vital to reduce fraud, waste, and abuse (FWA) in government health care programs. The best way to verify a Member's identity is to obtain a copy of the Member's ID card and a form of picture ID. Do you have suspicions of Member or Provider fraud? The Molina AlertLine is available to you 24 hours a day, seven days a week, even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.

Molina complies with all Federal and State requirements regarding fraud and abuse, including but not limited to, sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

Additional information of Fraud, Waste and Abuse is available in the Compliance section of this Provider Manual.

Claims for MLTSS Services

Providers are required to bill Molina for all MLTSS waiver services electronically, using EDI submission, or through the Availity Essentials portal, or by paper Claim submitted to the correct PO Box. The Availity Essentials portal, available at no-cost, offers additional features and

benefits. After registering, a Provider will be able to check eligibility, Claim status and create/submit Claims to Molina. To register please visit: Availity.com/MolinaHealthcare.

Once registered for Availity, you will be able to access trainings online and within the Availity Essentials portal that walk through the Claim submission process.

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is technology used to verify and document that authorized HCBS visits occur. EVV ensures that services are delivered to the Members needing services, and that billing is correct. Molina contracts with CareBridge for EVV.

Services that are required to use EVV include, but may not be limited to:

Service	HPCS Code	Units
Attendant Care	S5125	Per 15 Minutes
Homemaker Not Otherwise Specified (NOS)	S5130	Per 15 Minutes
Homemaker NOS	S5131	Per Diem
Personal Care Services	T1019	Per 15 Minutes

Atypical Providers

Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation and respite services, etc. Although they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina.

Atypical Providers are required to use the state assigned atypical NPI number given to them by the state of Iowa to take the place of the NPI.