Provider Manual

Molina Healthcare of Arizona, Inc. (Molina Healthcare)

Medicaid
2026

The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 12/2025

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1. INTRODUCTION

About Molina Healthcare

Molina Healthcare of Arizona (Molina) is an integrated health plan designed for the total care of individuals, including medical and behavioral health needs. Our clinical and operational model of care (clinical, quality and population health programs) enables us to offer our members access to high-quality, clinically appropriate, affordable health care that is tailored to each individual's needs. Our ultimate goal is to improve health care outcomes and the overall quality of life for our members and their families.

Molina is part of Molina Healthcare, Inc., a health care management company that focuses on fast-growing, complex, and high-cost areas of health care, with an emphasis on special population management.

Molina entered into a contract with the Arizona Health Care Cost Containment System (hereinafter referred to as "AHCCCS") for the provision of Medicaid managed care to individuals enrolled in the department's AHCCCS Complete Care program. Pursuant to the program requirements, Molina will provide the full scope of services and deliverables through an integrated and coordinated system of care as required, described, and detailed herein, consistent with all applicable laws and regulations, and in compliance with service and delivery timelines as specified by AHCCCS and within the Molina clinical, quality and population health program documents.

Molina complies with AHCCCS and applicable federal requirements, in addition to applicable accreditation standards. Molina is responsible for all covered services that are warranted for members until they change contractor per ACOM Policy 401.

Model of Care

Molina delivers an integrated model of care (MOC) specially designed for members of the AHCCCS Complete Care program.

Our MOC functions as the foundation for improving the health status of Arizonians by using person-centered and population-based care management, which is delivered through Integrated Health Neighborhood (IHN) teams, to integrate community resources and non-traditional services within local health systems. We ensure that natural and peer supports, housing and employment are in place, in addition to traditional behavioral and medical treatment.

Our providers are the key to our success in delivering population-based, person- centered care. The level of support and coordination provided is dependent on each individual member's needs, which may be outlined within an individualized service plan (SP). Molina's interdisciplinary care team (ICT) is comprised of the member and/or a designated representative and individuals engaged in the member's life, who represent the continuum of physical and behavioral health and social delivery systems and is based on their relationship and knowledge of the member. This ICT model ensures a collaborative approach to care management based on the level of service the member requires.

The composition of the ICT varies based on the member's needs and includes, at a minimum, the member or caregiver, primary and specialist providers, a care coordinator and/or care manager (CM) with both behavioral and physical health clinical expertise, peer support specialists, support

staff care coordinators and a health guide. The health guide and support staff care coordinators help the member navigate the physical and behavioral health delivery systems and ensure the member receives all necessary behavioral and physical health services in order to live independently in the community.

Molina brings the same commitment to the provider community in Arizona as we have in other parts of the country for the last 25 years. Together, we can leverage our strength, experience, and expertise to improve outcomes for individuals in need of comprehensive care.

Integrated Health Neighborhood^{SM}

Molina's goal to improve members' care and health outcomes can only be achieved within the context of where the members live—within their neighborhoods and communities. Our model builds an infrastructure with the health and social services system called the Integrated Health Neighborhood (IHN)SM, which customizes the delivery of care by region and supports and enhances the relationship between members and their providers.

Because our team members live and work within the communities where our members reside, these team members have firsthand knowledge of community strengths, resources, for Health Related Social Needs (HRSN), services, and service gaps. IHNSM team members include care coordinators and/or care managers, health guides, peer specialists and navigators and community outreach specialists supported by housing specialists, employment specialists, clinical pharmacists, medical directors, and others.

The IHNSM is Molina's mechanism to facilitate close collaboration with community partners, enhancing our ability to provide person-centered care to our members. This network naturally bridges language and cultural barriers, and more effectively and efficiently facilitates access to services to support our members and families where they live, work and play.

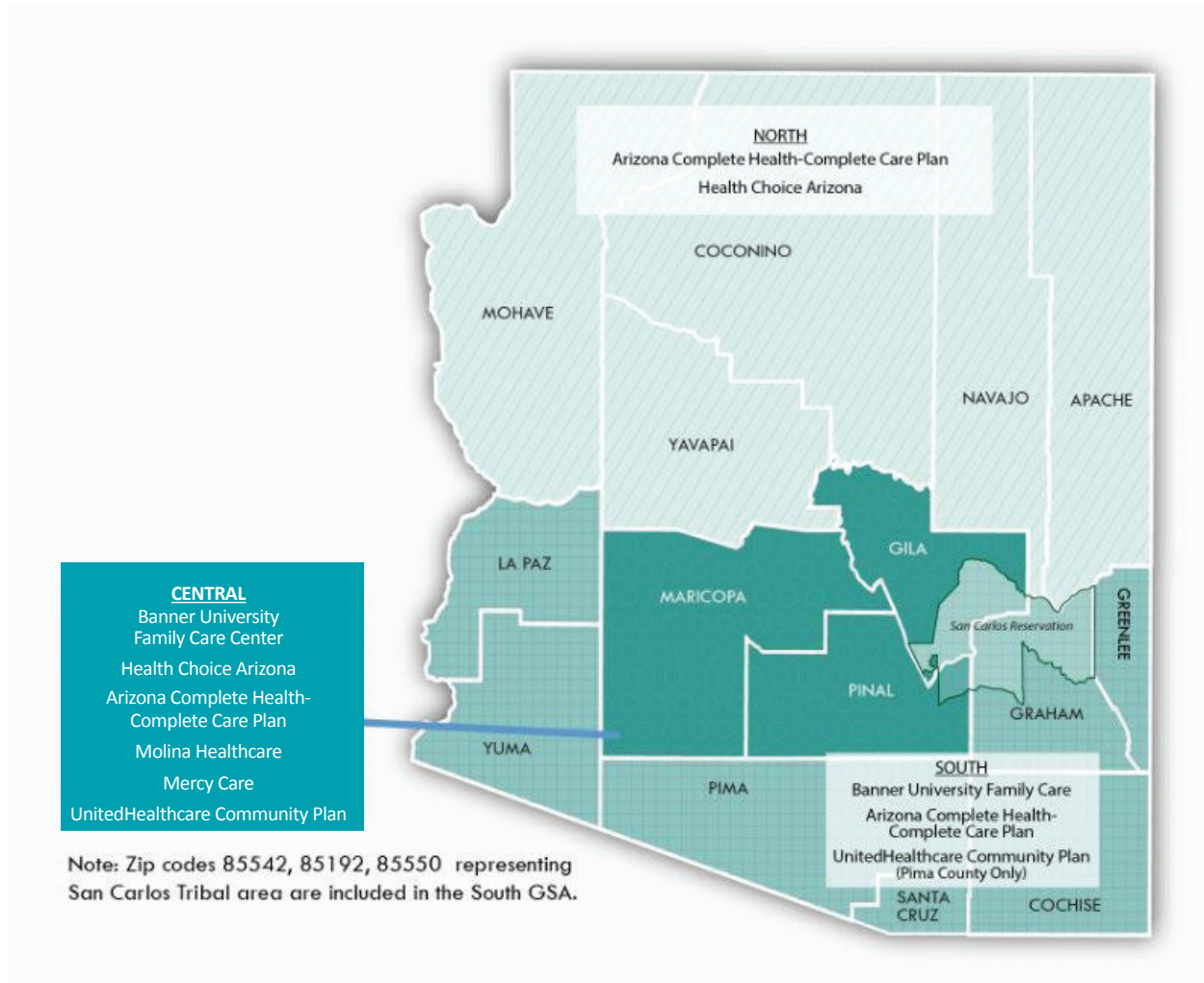Closed Loop Referral System (CLRS)-CommunityCares

Molina partners with Contexture and Unite Us for access to the CommunityCares CLRS to refer members for Health Related Social Needs (HRSN).

CommunityCares is a free tool available to help healthcare providers and community-based organizations quickly and efficiently screen and refer members for Health-Related Social Needs (HRSN), also known as Social Determinants of Health (SDOH). It streamlines the referral process, enabling organizations to track the individuals they are assisting. The program will provide updates and confirmation on services delivered and offer an up-to-date statewide resource directory via 2- 1-1 Solari Crisis and Human Services. Additionally, organizations have access to data tracking, analytics, and outcome measures.

If you are interested in CommunityCares, please sign up for an upcoming CommunityCares Information Session here:
events.uniteus.com/?state=arizona or email communitycares@contexture.org.

Molina Healthcare Service Area

CENTRAL
Banner University Family Care Center
Health Choice Arizona
Arizona Complete Health-Complete Care Plan
Molina Healthcare
Mercy Care
UnitedHealthcare Community Plan

NORTH
Arizona Complete Health-Complete Care Plan
Health Choice Arizona

SOUTH
Banner University Family Care
Arizona Complete Health-Complete Care Plan
UnitedHealthcare Community Plan (Pima County Only)

Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.

2. CONTACT INFORMATION

Molina Healthcare of Arizona, Inc.
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Provider Services

The provider services department manages telephone 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. All Provider Inquiries will be responded to within three (3) days and will be addressed within thirty (30) business days.

Email: MCCAZ-Provider@molinahealthcare.com
Phone: (800) 424-5891 (TTY: 711)
Fax: (888) 656-0369

Member Services

The Member Contact Center manages all telephone inquiries regarding benefits, eligibility/ identification, pharmacy inquiries, selecting or changing primary care providers (PCPs) and member complaints. Member Services representatives are available Monday-Friday 8 a.m. to 6 p.m. MST, excluding state holidays. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.

Phone: (800) 424-5891 (TTY: 711)

Claims

Molina strongly encourages participating providers to submit claims electronically (via a clearinghouse or the Availity Essentials portal) whenever possible.

- Access the Availity Essentials portal (www.availity.com/Molinacompletecare)
- EDI Payer ID MCC01

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

Claims Recovery

The claims recovery department manages recovery for overpayment and incorrect payment of claims.

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

Phone: (866) 642-8999

Compliance and Fraud AlertLine

Suspected cases of fraud, waste, or abuse must be reported to Molina. You may do so by contacting the Molina AlertLine or by submitting an electronic complaint using the website listed below. For additional information on fraud, waste, and abuse, please refer to 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
Website: MolinaHealthcare.alertline.com

Credentialing

The credentialing department verifies all information on the provider application prior to contracting and reverifies this information every three years, or sooner depending on Molina's Credentialing criteria. The information is then presented to the professional review committee to evaluate a provider's qualifications to participate in the Molina network. For additional information about Molina's Credentialing program, including Policies and Procedures, please refer to the Credentialing and Recredentialing section of this Provider Manual.

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 (7) days a week.

Phone: (800) 424-5891 (TTY: 711)

Health Care Services

The Health Care Services (HCS) Department combines Care Management (CM) and Utilization Management (UM) for an integrated model of care. UM conducts concurrent reviews on inpatient cases and processes prior authorizations and service requests.

The HCS department also performs care management for members who will benefit from care management services. Participating providers are required to interact with Molina's HCS department electronically whenever possible. Prior authorizations, service requests and status checks can be easily managed electronically.

Managing prior authorizations and service requests electronically provides many benefits to providers, such as:

- Easy access to 24/7 online submission and status checks
- Ensuring HIPAA compliance
- The ability to receive real-time authorization status updates

- The ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces costs associated with fax and telephonic interactions

Providers can contact the HCS Department by calling (800) 424-5891 (TTY: 711).

You may also fax service requests and clinical to (888) 656-2201 for medical and behavioral Inpatient or (888) 656-7501 for medical and behavioral prior authorization service requests.

For Advanced Imaging requests you can call (855) 714-2415 or fax the request to (877) 731-7218.

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

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

Availity Essentials portal: provider.MolinaHealthcare.com
Prior Authorization Fax: (888) 656-0369

Please see Health Care Services section under Provider Roles and Responsibilities for more information.

Health Management

Molina's health management programs will be incorporated into the member's treatment plan to address the member's health care needs.

Phone: (866) 891-2320

Behavioral Health

Molina manages all components of covered services for behavioral health. For member behavioral health needs, please contact us directly at (800) 424-5891, 24 hours per day, 365 days per year.

Pharmacy

Prescription drugs are covered through CVS/Caremark. A list of in-network pharmacies is available at MolinaHealthcare.com or by contacting Molina. Specialty Pharmacy requests covered under the medical benefit should also be directed to below:

Phone: (800) 424-5891 (TTY: 711)
Fax: (844) 271-6887

Dental

Dental Service Authorization requests should be directed to DentaQuest.

Phone: (800) 424-5891 (TTY: 711)
Fax: (262) 241-7150 -for non-hospital requests
Fax: (262) 834-3575 -for hospital and SPU requests

Quality

Molina maintains a quality department to work with members and providers in administering Molina's quality programs. If you have any questions or concerns, please contact Molina's Quality Department at:

Phone: (800) 424-5891 (TTY: 711)
Fax: (888) 656-0369
Email: Quality of care concerns, seclusion and restraint reporting:
         MCCAZ- QOC@MolinaHealthcare.com

         Provider audit questions: MCCAZ-Quality@MolinaHealthcare.com
         Performance improvement initiatives: MCCAZ-HEDIS@MolinaHealthcare.com

3. PROVIDER ROLES AND RESPONSIBILITIES

Non-discrimination 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. Providers serving Medicaid Members are required to maintain the same hours of operation as those offered to commercial benefit Members.

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

Phone: (866) 606-3889 (TTY: 711)
Online: www.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: 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 and Administrative Services

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).

Primary Care Provider Role

The primary care provider (PCP), with the support of the interdisciplinary care team (ICT), is responsible for the overall care of the member. This responsibility includes providing direct care, referring members for behavioral health, specialty, or ancillary care and coordinating care with the health plan and these providers for greater clinical outcomes.

A PCP must be:

- Currently licensed by the state of Arizona;
- A family practice, internal medicine, general practice, OB/GYN, or geriatrics practitioner; or
- A specialist who receives prior approval from Molina and performs primary care functions in locations that include, but are not limited to, Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; and

- In good standing with the federal and federal/state Medicaid (AHCCCS) program.

Primary Care Provider Assignment for Non-Dual Eligible Members

Molina assigns all non-dual eligible members to a PCP at the date of the member's enrollment. members may select a different in-network PCP at any time if they choose. When we call the member to schedule an initial assessment, we offer the member the opportunity to change their PCP assignment.

Our experience shows that members often require highly specialized primary care services to address their complex needs, along with related services and support. We prioritize PCP assignment with Federally Qualified Health Centers and Integrated Clinics so members can receive primary care services at a location that best meets their needs.

Primary Care Provider Assignment for Dual Eligible Members

For dual eligible members, we utilize all AHCCCS and Medicare information provided to us to identify the member's PCP and enhance our care management efforts. We assist the member in finding or changing a PCP, including contacting the individual's Medicare health plan care manager when necessary.

We work with PCPs to coordinate care and invite the individual to participate in ICTs. We inform dual eligible members about their right to access Medicare providers, regardless of whether the provider is in our network, and without having to obtain prior approval.

Primary Care Provider Medication Management Services

PCPs may provide treatment for behavioral health conditions within the scope of their practice. PCPs who treat behavioral health conditions may provide medication management, including prescriptions, laboratory, and other diagnostic tests necessary for diagnosis and treatment. Conversely, behavioral health providers may provide physical health care services if, and when, they are licensed to do so within the scope of their practice.

Behavioral health providers are required to submit demographic data via online portal for demographics, social determinants, and outcomes on the AHCCCS site at www.azahcccs.gov/PlansProviders/Demographics/.

Molina urges behavioral health providers to pay attention to communicating with the member's PCPs at the time of discharge from a behavioral health inpatient stay and/or whenever there is a significant change in the member's treatment plan, status, or symptomology. We recommend faxing the discharge instruction sheet or a letter summarizing the hospital stay, including prescribed behavioral health medications, to the PCP. Any changes that may impact the member's treatment plan should be noted. The PCP is also encouraged to share changes in the treatment plan and summary of hospitalization with the behavioral health providers.

Fostering a culture of collaboration and cooperation helps maintain a seamless continuum of care between medical and behavioral health and positively impacts member outcomes. If a member's medical or behavioral health condition or medication regimen changes, we expect that both PCPs and behavioral health providers will communicate those changes to each other. The ICT and CC and/or CM are available to help maintain continuity of care and coordination of members with complex needs by supporting communication between behavioral health and medical providers.

The Specialist Role

A specialist is any licensed provider providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary, including for behavioral health services (transition-aged youth, trauma, substance use in adolescents, opioid use disorder, supportive and rehabilitation services), autism spectrum disorder, services for members birth to five, and social determinants of health needs. A PCP may communicate with a specialist directly to coordinate care, or a member may self-refer. If a PCP needs help finding a specialty provider for any area in the Molina network, they may contact Molina at (800) 424-5891 (TTY: 711) and request a care manager. Some services require a prior authorization. Specialists must obtain a prior authorization from Molina before performing specific procedures or when referring members to non-contracted providers.

Please refer to our website at MolinaHealthcare.com for services that require prior authorization. Providers can review prior authorization requirements in the summary of benefits or the evidence of coverage or by calling us at (800) 424-5891 (TTY: 711)..

The specialist should:

- Communicate the member's condition and recommendations for treatment or follow- up with the PCP
- Include the following in the PCP communication: medical findings, test results assessments, treatment plan and any other pertinent information
- Understand that if a specialist needs to refer a member to another provider, the referral should be to another Molina participating provider
- Be aware that any referral to a non-participating provider will require a prior authorization from Molina

Specialist as the Primary Care Provider

With prior approval from Molina, a specialist may act as the PCP for a member. This role modification is often beneficial for members who have a life threatening, degenerative and/or disabling condition, or a disease requiring prolonged specialized medical care. The member's PCP is responsible for requesting a specialist to assume the PCP function. Such requests should be made to the utilization and/or care management department and must be approved by the medical director.

Provider Rights and Responsibilities

Molina is dedicated to selecting health care professionals, groups, agencies, and facilities to provide member care and treatment across a range of covered services as defined by AHCCCS.

AHCCCS Provider portal can be accessed here: AHCCCS Provider Enrollment (azahcccs.gov).

Providers can and should update their information on this portal with AHCCCS along with notifying Molina of any changes.

Network Provider Participation

To be a network provider of health care services with Molina under the AHCCCS Complete Care program, each provider must be credentialed and contracted according to Molina and AHCCCS

standards. All providers are subject to applicable licensing requirements.

As a Molina network provider of health care services, each provider's responsibilities include:

1. Providing medically necessary covered services to members whose care is managed by Molina;
2. Following the policies and procedures outlined in this manual, any applicable supplements, and the provider participation agreement(s) as well as AHCCCS policies and regulations;
3. Providing services in accordance with applicable state of Arizona and federal laws and licensing and certification bodies. Contracted providers for the AHCCCS Complete Care program network are required to abide by AHCCCS regulations and manuals and maintain active licensure for their contracted provider type and specialty at each service location. AHCCCS regulations and manuals can be found online at www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html;
4. Providing covered services to Molina members as outlined in this manual, applicable supplements and provider agreement(s), as well as AHCCCS policies and regulations without exclusion or restriction on the basis of religious or moral objections.
5. Agreeing to cooperate and participate with all systems of care management, quality improvement, outcomes measurement, peer review and appeal and grievance procedures;
6. Participation in Value-Based Purchasing (VBP) initiatives that impact member assignment as specified in AMPM Policy 510.
7. Making sure only providers currently credentialed with Molina render services to Molina members; and
8. Following Molina's credentialing and recredentialing policies and procedures.

Molina's responsibility is to:

1. Help with a provider's administrative questions during normal business hours, Monday through Friday; 8 a.m. to 6 p.m.
2. Not prohibit, or otherwise restrict health care providers acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered, any information the member may need in order to decide among all relevant treatment options, the risks, benefits and consequences of treatment or non-treatment and not prohibit nor restrict the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
3. Assist providers in understanding and adhering to our policies and procedures, the payer's applicable policies and procedures and other requirements including but not limited to those of the National Committee for Quality Assurance (NCQA); and
4. Maintain a credentialing and recredentialing process to evaluate and select network providers that does not discriminate based on a member's benefit plan coverage, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability, or other status protected by applicable law.

Provider Data Accuracy and Validation

It is important for providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our members and provider network.

Maintaining an accurate and current provider directory is a state and federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact member access to care, member and/or PCP assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Please visit our Provider Online Directory at Find a Healthcare Provider to validate your information. Providers must validate their Provider information on file with Molina at least once every ninety (90) days for correctness and completeness.

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

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

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

Please visit our Provider Online Directory at MolinaHealthcare.com to validate your information.

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

Molina may also 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.

All Molina providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with AHCCCS and meet the Medicaid Provider enrollment requirements set forth in the AHCCCS Provider Enrollment Portal (APEP) Overview and Basic Provider Information for fee-for-service Providers of the appropriate provider type.

National Plan and Provider Enumeration System Data Verification

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

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

Molina supports the CMS recommendations around NPPES data verification and encourages our provider network to verify provider data online at www.nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data. Additional information regarding the use of NPPES is available in the frequently asked questions (FAQs) document published online at: www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Participation

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 aren't limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic claims appeal and registration for and use of the Availity Essentials Portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity Essentials Portal.

Any provider entering the network as a contracted provider will be encouraged to comply with Molina's electronic solution policy by enrolling for EFT/ERA payments and registering for the Availity Essentials Portal within thirty (30) days of entering the Molina network.

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

Electronic Solutions and Tools Available to Providers

Electronic tools/solutions available to Molina providers include:

- Electronic claims submission options
- Electronic payment: EFT with ERA

Availity Essentials portal: availity.com/providers

Electronic Claim Submission Requirement

Molina strongly encourages participating providers to submit claims electronically whenever possible. Electronic claim 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 claim submission options:

- Submit claims directly to Molina via the Availity Essentials Portal.
- Submit claims to Molina through your EDI clearinghouse using Payer ID MCC01. Refer to our website at 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 claims through direct data entry Submit claims through quick claims entry and saving templates
- Submit corrected claims
- Add attachments to corrected claims
- Add attachments to pending 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/unsubmitted claims
- Create and/or manage claim templates

For additional information on EDI claims submission and paper claims submission, please refer to the Claims and Compensation section of this provider manual.

Electronic Payment (EFT/ERA) Requirement

Participating providers are strongly encouraged to enroll in EFT and 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.

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

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

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:

- The ability to verify member eligibility, covered services and view HEDIS needed services (gaps)
- Claims:
  - o Submit professional (CMS1500) and institutional (UB04) claims with attached files
  - o Correct/void claims
  - o Add attachments to previously submitted claims
  - o Check claims status
  - o View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - o Create and manage claim templates
  - o Submit and manage Claim disputes, including formal appeals or reconsideration requests, for finalized Claims
    - ▪ View, dispute, resolve Claim overpayments
- Prior authorizations/service requests
  - o Create and submit prior authorizations and/or service Requests
  - o Check status of prior authorizations and/or service requests
- Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
- Download forms and documents
- Send/receive secure messages to and from Molina
- Manage Overpayment invoices (Inquire, Dispute and Resolve)

Provider network management portal: enrollment tool

The Provider Network Management Portal is a secure, free tool used to manage Provider enrollment and credentialing requests. All credentialing requests for a Provider to join the network must be submitted electronically through the portal.

Available functions include:

- Adding practitioners to an existing group
- Submitting credentialing requests
- Tracking credentialing and participation status
- Providing additional or missing information for enrollment or credentialing
- Uploading provider rosters
- Adding new facility locations

Access

Office managers, administrative personnel, or Providers who need access to the portal for the first time must submit a registration request directly through the Provider Network Management Portal at Molina/Provider Management.

Balance Billing

Pursuant to Law and CMS guidance, Members who are dually eligible for Medicare and Medicaid and classified as Qualified Medicare Beneficiaries (QMB) shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts. 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 Molina member for covered services is prohibited, except for the member's applicable copayment, coinsurance, and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the member rights and responsibilities as outlined in Molina's member materials (such as member handbooks).

For additional information please refer to the member rights and responsibilities section 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: availity.com/providers
- Molina Provider Contact Center automated Interactive Voice Response (IVR) system at (800) 424-5891 (TTY: 711)

For additional information, please refer to the member eligibility, enrollment and disenrollment section of this provider manual.

Member Cost Share

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

DUGless Data Reporting Requirements

For those demographic elements with no identified alternative data source or Social Determinant identifier, AHCCCS created an online portal (DUGless) to be accessed directly by providers for the collection of the remaining data elements for members including, but not limited to:

1. Access and utilization of services.
2. Community and stakeholder information.
3. Compliance with Federal, State, and grant requirements
4. Health disparities and inequities.
5. Member summaries and outcomes.
6. Quality Management (QM) and MM activities.
7. Social Determinants Of Health (SDOH).
8. CALOCUS level of care identification as specified in AMPM Policy 580.
9. Serious Emotional Disturbance (SED) Identification to include SED qualifying diagnoses

Providers must submit these required data elements via the DUGless portal on the Provider AHCCCS Online. The requirements, definitions, and values for submission of the identified data elements are specified in the AHCCCS DUGless Portal Guide.

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, concurrent and medical necessity review determination, and 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.

Utilization Management

The purpose of the Molina utilization management program is to support optimal use of health care services and supports for the evaluation, treatment, and integration of medical, dental, and behavioral health conditions. The Molina utilization management and care management teams collaborate to ensure seamless, timely and accurate care and service authorization processes.

The program meets its objectives in part by conducting prospective, concurrent, retrospective and discharge planning review of services rendered to its members. The utilization department monitors quality, continuity, and coordination of care as well as overutilization/underutilization and medical necessity of services. High-risk/high-cost cases are followed closely by the HCS staff to ensure that the most cost-effective services are identified, coordinated, implemented, and evaluated on a continual basis. Services provided are not less than the amount, duration and scope for the same services delivered to fee-for-service (FFS) Medicaid members. Medically necessary services are not more restrictive than used in the state-defined program. Molina makes the utilization management criteria available in writing, by mail, or fax for providers and members. Molina supports continuity and coordination of care for physical, dental, and behavioral health providers.

Providers can call our toll-free number at (800) 424-5891 with any utilization management questions.

- Our Molina team members are available for incoming calls Monday-Friday 8 a.m. to 6 p.m. MST

- Our Molina team members can receive incoming calls regarding utilization management concerns after normal business hours
- Our Molina team members can send out communications regarding questions during normal business hours, unless otherwise agreed upon
- Our Molina team members are available to accept collect calls
- Our Molina team members will identify themselves by name, title and our organization name of Molina when initiating or returning calls
- Our Molina team members are available to callers who have questions about the utilization management processes
- A utilization management dedicated fax line and electronic portal can be used to submit requests for medical necessity determinations 24 hours a day/7 days a week
- An after-hours, on-call nurse is available for emergent and/or urgent concerns

In addition, the Health Care Services Department is charged with developing, implementing, and continuously monitoring the Medical Management Work Plans. The utilization management team collaborates with the care management and health services teams to ensure that all work plans are coordinated between departments. The Medical Management program generates policy and procedures and provides general direction and guidance toward policy execution. The Medical Management Committee and the Quality Improvement Committee (QIC) work together to ensure the health and well-being of individuals enrolled in Molina. This is achieved through the development and administration of health care benefits and health care coordination processes that facilitate the availability and accessibility of services in accordance with corporate policies, federal, state, and local regulations and accreditation standards.

For additional information and additional Provider Roles and Responsibilities 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 online at MolinaHealthcare.com.

Additional information regarding in-network laboratory providers and in-network laboratory provider patient service centers can be found on the laboratory providers' respective websites at www.appointment.questdiagnostics.com/patient/confirmation and www.labcorp.com/labs-and-appointments.

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

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

Referrals

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

Providers should direct Molina members to health professionals, hospitals, laboratories and other facilities and providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and emergency services, providers may direct members to an appropriate service including, but not limited to:

- Primary care
- Urgent care
- 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 may 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 providers and members regarding medically necessary or appropriate patient care, regardless of covered benefit 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

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information, please refer to the covered pharmacy services 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 recordkeeping practice reviews, as applicable
- Delivery of patient care information

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

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of Molina members.

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that providers respect the privacy of Molina members (including Molina members who are not patients of the provider) and comply with all applicable laws and regulations regarding the privacy of patient and member PHI. For additional information, please refer to the compliance section of this provider manual.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's grievance program and cooperate with Molina in identifying, processing and promptly resolving all member complaints, grievances, or inquiries. If a member has a complaint regarding a provider, the provider will participate in the investigation of the grievance. If a member submits an appeal, the provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of member records for a period of no less than ten (10) years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information, please refer to the member grievances and appeals section of this provider manual.

Participation in Credentialing

Providers are required to participate in Molina's credentialing and recredentialing process and will satisfy, throughout the term of their contract, all credentialing and recredentialing 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 recredentialing process.

More additional information on Molina's credentialing program, including policies and procedures, please refer to 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. For additional information on Molina's delegation requirements and delegation oversight please refer to the Delegation section of this Provider Manual.

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

Centers of Excellence

Molina Healthcare's Centers of Excellence are designed to meet the needs of our members as well as contractual requirements. A Center of Excellence is a facility and/or program that is recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, patient satisfaction and better member outcomes that is recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, patient satisfaction and better member outcomes.

Molina's approach begins first by assessing our provider's procedure volumes and historical effectiveness in treating selected conditions or cohorts of high-risk members, based on publicly available and reportable member data. Next, working with our physician partners, we assess the following criteria to select providers as a Center of Excellence:

- Satisfaction of our Member
- Improvement in Prevention, Education and Wellness
- Quality of Care Outcomes (closing HEDIS Gaps in Care)
- Value of Care Achieved
- Reduction in Emergency Department use
- Reduction in Inpatient Admissions/Readmissions
- Assessing Social Determinants of Health and Securing Resources to Address SDOH
- Trauma Informed Care Approach
- Evidence Based Programming

Based on our assessment and evaluation of data, we will consider these healthcare institutions and providers as Centers of Excellence. We will then work with these institutions and providers to develop clear goals and specific strategies, direction, accountability and monitoring to align hospitals, facilities and physicians with our members to provide the best possible opportunities for members to manage their health and well-being.

Health Home

Molina Healthcare has developed partnerships with specific providers to serve as health homes for our members in order to ensure high quality services. While other providers might meet the health home definition, members can only be assigned to providers that Molina has specifically identified as a health home.

A health home is a provider that provides or coordinates the provision of all primary, physical health, behavioral health, and services and supports to treat the whole person. They provide, or coordinate, a range of recovery focused services to members such as medication services, case management, transportation, peer and family support services, social services, and health and wellness groups. Additionally, the health home ensures follow up and continuing care after someone has received crisis services.

Members are not required to receive services from their health home. Regardless of assignment, the member retains their ability to choose where they receive services from and can continue to receive services from any behavioral health or physical health provider they would like.

Trauma Informed Providers

Molina Healthcare promotes the provision of Trauma Informed Care (TIC) service delivery approaches. We ensure our providers implement routine trauma screenings using validated tools. Molina has a network of therapists trained and certified in trauma focused evidence-based practices.

If providers are interested in trauma informed training, they can find trauma webinars available on the Relias platform.

4. CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Background

Molina works to ensure all members receive culturally and linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic and accessibility related needs of individuals served. Molina complies Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, and national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all implementing regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all members, including those with Limited English Proficiency (LEP) and members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability.

Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, sexes, ages and religions, as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each. Additional information on culturally and linguistically appropriate services is available on the Availity Essentials portal (Go to Payer spaces, Resources Tab), from your local provider services representative and by calling Molina at (800) 424-5891.

Non-discrimination 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 MolinaHealthcare.com.
3. You MUST post in a conspicuous location in your office, a Tagline Document, which explains how to access non-English language services at no cost. A sample of the Tagline Document that you will post can be found in the Member Handbook located at MolinaHealthcare.com.
4. If a Molina member is in need of accessibility-related services, you MUST provide reasonable accommodations for individuals with disabilities and appropriate auxiliary aids and services
5. If a Molina member needs 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

6. ("LEP"). You can find resources on meeting your LEP obligations at Limited English Proficiency (LEP) | HHS.gov and Limited English Proficiency Resources for Effective Communication | HHS.gov. 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: 711 Email: civil.rights@Molina Healthcare. com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **Website:** https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf **Complaint Form:** https://www.hhs.gov/ocr/complaints/index.html

If you or a Molina Member need additional help or more information call the Office of Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697 for persons with hearing impairments.

Culturally and linguistically appropriate practices Molina is committed to reducing health care disparities and improving health outcomes for all members. Training employees, providers and their staff, and improving appropriateness and accessibility are the cornerstones of assessing, respecting and responding to a wide variety of cultural, linguistic and accessibility needs when providing health care services. Molina integrates culturally and linguistically appropriate practices training into the overall provider training and quality monitoring programs. An integrated quality approach enhances the way people think about our members, service delivery and program development so that culturally and linguistically appropriate practices become a part of everyday thinking.

Molina provides interpreter access for members from culturally and linguistically diverse backgrounds, and for people with hearing, speech, and communication impairments. Interpreter services for all languages, including sign language, are provided at no cost to our members. Molina facilitates language assistance provided to LEP members, including how to work with interpreters and telephone language services or working with translated written materials. Members, or providers on behalf of a member, can schedule an on-site interpreter by calling Molina at (800) 424-5891 to request interpretation services.

Molina's telephone language line is available 24 hours a day, 7 days a week. Participants who are hearing impaired or have speech impairment have access to the TTY/TDD service line by calling TTY/TDD: 711. Participants who do not have TTY/TDD can communicate with a TTY/TDD user through Message Relay Center (MRC). MRC has TTY/TDD operators available to send and interpret TTY/TDD messages.

Molina continually assesses network composition by actively recruiting, developing, retraining, and monitoring a diverse provider network compatible with the member population.

We depend on our providers to:

1. Provide Molina with information on languages spoken by the provider or the provider's staff.
2. Provide Molina with any practice specialty information the provider holds on the provider credentialing application.
3. Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to people with (LEP) at all points of contact. Oral interpretation services are provided at no cost to members. Members must be provided with information instructing them on how to access these services. Interpretation services are the facilitation of oral or sign language communication, either simultaneously or consecutively, between users of different languages.
4. Translate any documents that require the signature of the member and that contains vital information regarding treatment, medications, or service plans into their preferred and/or primary language if requested by the member or his/her guardian.
5. Inform us if the provider objects to the provision of any counseling, treatments, or referral services on religious grounds.

Molina's responsibility is to:

1. Provide ongoing education to help providers deliver culturally informed services to people of all cultures, races, ethnic backgrounds, religions, and those members with disabilities.
2. Provide language assistance, including bilingual staff and interpreter services, to those with LEP during all hours of operation at no cost to the member.
3. Assist providers in locating interpreters for our members when requested by the member or when requested by the provider.
4. Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area.
5. Monitor gaps in services and other culturally specific provider service needs. When gaps are identified, Molina will develop a provider recruitment plan and monitor its effectiveness.

Provider and Community Training

Molina offers educational opportunities in culturally and linguistically appropriate practices and concepts for providers and their staff. 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 culturally and linguistically appropriate training
3. Online culturally and linguistically appropriate provider training
4. Integration of culturally and linguistically appropriate practices and concepts and nondiscrimination of service delivery into provider communications.

Integrated Quality Improvement

Molina ensures member access to language services such as oral interpretation, American Sign

Language (ASL), written materials in alternate formats, 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 format), leading to better communication, understanding and member satisfaction. Online materials 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, is also available in threshold languages on the Molina member website.

Access to Language Services

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. All eligible Members with LEP are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP) or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist providers with locating these services if needed.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.
- Be given access to Care Managers trained to work with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services, including ASL, are available at no cost
- Be given reasonable accommodations, appropriate auxiliary aids and services.
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
  o Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
  o Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
  o Interpreters must ensure that this shared information is similarly safeguarded

- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.

Interpreters include people who can speak the member's primary language, assist with a disability or help the Member understand the information.

When Molina Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
  - o Providers needing assistance finding on-site, video remote, or telephonic interpreter services.
  - o Providers needing assistance obtaining written materials in preferred languages.
  - o Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD Relay service at 711.
  - o Providers with Members with limited vision may contact Molina for documents in large print,
  - o braille or audio version.
  - o Providers with Members with limited reading proficiency.
    - ▪ The Molina Member Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Documentation

As a contracted Molina provider, your responsibilities for documenting member language services and/or 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

TTY/TDD connection accessible by dialing 711. This connection provides access to the member and provider contact center, quality, health care services and all other health plan functions.

Molina strongly recommends that provider offices make assistive listening devices available for members who are deaf or 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 on-site or video service delivery for ASL to support our members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, members will have made this request via Member Services.

The provider must ensure that the programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. Specifically, providers shall comply with the ADA (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its members by:

1. Providing flexibility in scheduling to accommodate the needs of members;
2. Providing interpreters or translators for members who are deaf and hard of hearing and those who do not speak English;
3. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual, and include but are not limited to:
   a. Ensuring safe and appropriate physical access to buildings, services, and equipment;
   b. Ensuring providers allow extra time for members to dress and undress, transfer to examination tables and extra time with the practitioner in order to ensure that the individual is fully participating and understands the information

Nurse Advice Line

Molina provides nurse advice services for members 24 hours per day, seven (7) days per week. The Nurse Advice Line provides access to 24-hour interpretive services. members may call Molina's Nurse Advice Line directly at (800) 424-5891 (TTY: 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:
  o Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  o Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network and cultural responsiveness.
- Collection of data and reporting for the Diversity of membership HEDIS® measure.
- Collection of data and reporting for the Language Description 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 across the Plan's subpopulatons.

Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Qualified Health Plan (QHP) Enrollee Experience Survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

5. 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. Member rights and responsibilities are outlined under the heading "Your Rights and Responsibilities" within the member handbook document.

The most current member rights and responsibilities can be accessed via the following link: www. MolinaHealthcare.com/members/az/en- us/mem/medicaid/member-materials- and- forms.aspx. (see **What to expect as a Molina Member** in the Member Handbook)

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 (800) 424-5891 (TTY: 711) Monday- Friday, 8 a.m. to 6 p.m. MST.

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.

6. MEMBER ELIGIBILITY, ENROLLMENT, DISENROLLMENT

Enrollment

Enrollment in Medicaid Programs

The AHCCCS Complete Care program provides integrated care addressing physical health and behavioral health needs for the following Title XIX/XXI populations:

1. Adults who are not determined to have a Serious Mental Illness excluding DES/DDD enrolled members,
2. Children, including those with special health care needs; excluding DES/DDD and DCS/CMDP enrolled members, and
3. Members determined to have SMI who opt to transfer to the Contractor for the provision of physical health services as outlined in ACOM Policy 442.

Eligibility Groups

The AHCCCS Complete Care program is made up of multiple groups, each with distinct eligibility and/or enrollment requirements and benefits:

Title XIX

1. Parents/caretaker relatives: Eligible individuals under the 1931 provision of the Social Security Act, with income at or below 106% of the FPL.
2. Supplemental security income (SSI) cash: Eligible individuals receiving SSI through federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or who have a disability and have income at or below 100 percent of the federal benefit rate (FBR).
3. SSI medical assistance only (SSI MAO) and related groups: Eligible individuals who are aged, blind or who have a disability and have household income levels at or below 100% of the FPL.
4. Freedom to work (ticket to work): Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.
5. Pregnant women: Eligible pregnant women, with income at or below 156% of the FPL,
6. Children: Eligible children with incomes ranging from below 133% to 147% of the FPL, depending on the age of the child.
7. Breast and cervical cancer treatment program (BCCTP): Eligible individuals under the Title XIX expansion program for women with incomes at or below 250% of the FPL who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs. Eligible members cannot have other creditable health insurance coverage, including Medicare.
8. Title IV-E foster care and adoption subsidy: Children who are in state foster care or are receiving federally funded adoption subsidy payments.
9. Young adult transitional insurance (YATI): Transitional medical care for individuals of age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday.
10. Adult group at or below 106% FPL: Adults aged 19-64 without Medicare, with income at or below 106% of the FPL (Adults </= 106%).

11. Adult group above 106% FPL: Adults aged 19-64 without Medicare, with income above 106% through 133% of the FPL (Adults > 106%).

Title XXI

1. *KidsCare:* Federal and State Children's Health Insurance program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services and behavioral health care services statewide to eligible children under the age of nineteen (19) in households with income between 133% and 225% of the FPL.

State-Only Transplants

1. Working directly with a Molina designated transplant coordinator, Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility under a category other than adult group, may become eligible for and select one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:

   - The individual has been determined ineligible for Title XIX due to excess income,
   - The individual had been placed on a donor wait list before eligibility expired, and
   - The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

2. The following options for extended eligibility are available to these members:

   - Option one: Extended eligibility is for one 12-month period immediately following the loss of AHCCCS eligibility. The member is eligible for all AHCCCS covered services as long as they continue to be medically eligible for a transplant. If determined medically ineligible for a transplant at any time during the period, eligibility will terminate at the end of the calendar month in which the determination is made.
   - Option two: The member loses AHCCCS eligibility but maintains transplant candidacy status as long as medical eligibility for a transplant is maintained. At the time the transplant is scheduled to be performed, the transplant candidate will reapply and will be re-enrolled with his/her previous Contractor to receive all covered transplant services. Option two-eligible individuals are not eligible for any non-transplant related health care services from AHCCCS.

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

Effective Date of Enrollment

The effective date of enrollment for a new Title XIX member with Molina is the day AHCCCS takes the enrollment action. Molina is responsible for payment of medically necessary covered services retroactive to the member's beginning date of eligibility, as reflected in PMMIS.

The effective date of enrollment for a Title XXI member will be the first day of the month following notification to Molina. In the event that eligibility is determined on or after the 25th day of the month, eligibility will begin on the first day of the second month following the determination 42 CFR 457.1201(m), 42 CFR 457.1212.

In general, eligibility for AHCCCS medical assistance is determined on a month-by- month basis. A member may be eligible or ineligible for any specific month.

Rules that affect all programs:

- For a person that moves to Arizona from out of state, medical assistance eligibility cannot start any earlier than the date of the move to Arizona.
- For a person that has been in jail, prison or another detention facility, medical assistance eligibility cannot start any earlier than the date the person no longer meets the definition of an inmate.
- For a newborn child, medical assistance eligibility cannot start any earlier than the newborn's date of birth.

Otherwise, the date eligibility starts varies by program. See the table below:

Program	Eligibility Begin Date
Medicare Savings Program (MSP)-QMB	QMB eligibility begins with the month following the month that QMB eligibility is determined.
Breast and Cervical Cancer Treatment Program (BCCTP)	BCCTP eligibility begins on the later of: • First day of the application month (the application month for BCCTP is the month of the BCCTP diagnosis); or • First day of the first month in which the member meets
KidsCare	• If eligibility is determined by the 25th day of the month, eligibility begins with the first day of the following month. • If eligibility is determined after the 25th day of the month eligibility begins the first day of the second month following the determination.
All other programs	First day of a month, if the member is eligible at any time during that month.

Newborn Enrollment

Newborns born to AHCCCS eligible mothers enrolled at the time of the child's birth will be enrolled with the mother's Molina benefits (except as noted in the following paragraph), when newborn notification is received by AHCCCS. Molina is responsible for notifying AHCCCS of a child's birth to an enrolled member. Capitation for the newborn will be retroactive to the date of birth if notification is received no later than one day from the date of birth. In all other circumstances, capitation for the newborn will begin on the date notification is received by AHCCCS. The effective date of AHCCCS eligibility for the newborn will be the newborn's date of birth, and Molina is responsible for all covered services to the newborn, whether or not AHCCCS has received notification of the child's birth. AHCCCS is available to receive notification 24 hours a day, 7 days a week via the AHCCCS website. Each eligible mother of a newborn is sent a choice notice advising her of her right to choose a different health plan for her child; the date of the change will be the date of processing the request

from the mother. If the mother does not request a change within 90 days, the child will remain with the mother's Molina benefits.

Eligibility Verification

Medicaid Programs

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

Eligibility Listing for Medicaid Programs

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

- Molina Provider Contact Center at (800) 424-5891 (TTY: 711)
- Eligibility can also be verified through www.AZAHCCCS.gov
- Availity Essentials portal: www.availity.com/Molinacompletecare

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

Identification Cards

Molina Sample Member ID Card

<u>**Card front**</u>

Card back

In case of emergency, go to the nearest emergency room or call 911. Notify Molina as soon as within 48 hours of being admitted.
Nurse Advice Line: (800) 424-5891 (TTY/TDD: 711)
Transportation: (800) 424-5891 (TTY/TDD: 711)
Claims/Billing/Authorization/Eligibility: (800) 424-5891 (TTY/TDD:711)
Pharmacy: (800) 424-5891 (TTY/TDD: 711)
Website: www.MolinaHealthcare.com

Mail claims to: Payer ID#: MCC01
Molina Healthcare, Claims Service Center
2371 Grand Ave, P.O. Box 93152 Long Beach, CA 90809-9994

Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit www.MolinaHealthcare.com.

Members are reminded in their member handbook to carry ID cards with them when requesting medical or pharmacy services. It is the provider's responsibility to ensure Molina members are eligible for benefits and to verify PCP assignment prior to rendering services. Unless an emergency medical condition exists, providers may refuse service if the member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

An AHCCCS member may request disenrollment at the following times:

1. For cause at any time, which includes poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in addressing the member's care needs;
2. Without cause 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later;
3. Without cause at least once every 12 months;
4. Without cause upon re-enrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period.

When a member requests disenrollment for cause, the member must use Molina's grievance and appeal system process for the request, and Molina shall issue a decision no later than 30 days from the date of the request. If Molina approves the disenrollment, AHCCCS is not required to make a determination.

The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member or Molina files the request.

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

Involuntary Disenrollment

AHCCCS will disenroll the member from Molina:

1. When the member becomes ineligible for the AHCCCS program,
2. In certain situations when the member moves out of the Contractor's service area,
3. When the member changes Contractors during the member's open enrollment and annual enrollment choice period,
4. When the Contractor does not, because of moral or religious objections, cover the service the member seeks unless the Contractor offered a solution that was accepted by AHCCCS in accordance with the requirements in Section D, Paragraph 9, Scope of Services,
5. When the member is approved for a Contractor change through ACOM Policy 401,
6. When the member is eligible to transition to another AHCCCS program,
7. When the member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk, or for cause.

PCP Assignment

PCP assignment for non-dual eligible members: Molina assigns all non-dual eligible members to a PCP at the date of the member's enrollment. Members may select a different in-network PCP at any time if they choose. When we call the member to schedule an initial assessment, we offer the member the opportunity to change their PCP assignment. Our experience shows that members often require highly specialized primary care services to address their complex needs, along with related services and supports. We prioritize PCP assignment with Federally Qualified Health Centers and integrated clinics, so members can receive primary care services at a location that best meets their needs. Providers can request a membership assignment roster at MCCAZ- Provider@MolinaHealthcare.com. PCP assignment rosters will be returned to the Provider within ten (10) business days of the request. PCP membership rosters include at the minimum the following:

- Assigned members' name
- Assigned members' date of birth
- Assigned members' AHCCCS ID
- Providers AHCCCS ID and
- Effective date of the assignment to the member

PCP assignment for dual eligible members: For dual eligible members, we utilize all AHCCCS, and Medicare information provided to us to identify the member's PCP and enhance our care management efforts. We assist the member in finding or changing a PCP, including contacting the individual's Medicare health plan care manager when necessary. We work with PCPs to coordinate care and invite the individual to participate in ICTs. We inform dual eligible members about their right to access Medicare providers, regardless of whether the provider is in our network, and without having to obtain prior approval.

7. BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and covered services for Molina 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 (800) 424-5891 (TTY: 711) Monday-Friday, 8 a.m. - 6 p.m. MST.

Member Cost Sharing

Cost sharing is the deductible, co-payment, or co-insurance that members must pay for covered services provided under their Molina plan. Additional details regarding cost sharing are listed in the summary of benefits.

It is the provider's responsibility to collect the co-payment and other member cost sharing from the member to receive full reimbursement for a service. The amount of the co-payment and other cost sharing will be deducted from the Molina payment for all claims involving cost sharing.

Covered Services

Services 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. You may also contact Molina at (800) 424-5891 (TTY: 711) Monday-Friday 8 a.m. to 6 p.m. MST.

Non-covered services include but may not be limited to:

- Services from a provider who is NOT contracted with Health Plan (unless prior approved by the Health Plan)
- Cosmetic services or items
- Personal care items such as combs, razors, soap etc.
- Personal care services provided by a member's spouse
- Any service that needs prior authorization that was not prior authorized
- Services or items given free of charge, or for which charges are not usually made
- Services of special duty nurses, unless medically necessary and prior authorized
- Therapy that is not medically necessary
- Routine circumcisions
- Services that are determined to be experimental by the health plan medical director
- Health services if you are in prison
- Experimental organ transplants, unless approved by AHCCCS
- Sex change operations
- Reversal of voluntary sterilization
- Penile implants or vacuum devices
- Medications and supplies without a prescription
- Prescriptions not on our list of covered medications, unless approved by the Health Plan
- Physical exams for qualifying for employment or sports activities
- Hearing aids, including bone-anchored hearing aids. Microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs;

- Routine eye examinations for prescriptive lenses or glasses
- Routine dental services and emergency dental services, unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw
- Treatment to straighten teeth, unless medically necessary and approved by the Health Plan
- Outpatient speech therapy (except for Medicare QMB members)
- Diagnosis and treatment of TMJ is not covered except for reduction of trauma
- Immunizations for members for passport, visa clearance, or for travel outside of the United States
- Foods that are available in the grocery store or health food store are not covered as a metabolic food

Genetic testing is not covered under the following circumstances:

- To determine the likelihood of associated medical conditions occurring in the future,
- As a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly,
- For purposes of determining current or future reproductive decisions,
- For determining eligibility for a clinical trial , or
- Paying for panels or batteries of tests that include one or more medically necessary tests, along with tests that are not medically necessary, when the medically necessary tests are available individually.

Adult Emergency Dental Services Limitations for Persons age 21 Years and Older:

- Maxillofacial dental services provided by a Dental Provider are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.
- Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
- Routine restorative procedures and routine root canal therapy are not emergency dental services.
- Treatment for the prevention of pulpal death and imminent tooth loss is limited to non- cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection.
- Fixed bridgework to replace missing teeth is not covered.
- Dentures are not covered.

The following services are not covered Observation Services:

- Substitution of Observation Services for physician ordered inpatient services.
- Observation Services that is not reasonable, cost effective, and necessary for diagnosis or treatment of member.
- Observation Services provided solely for the convenience of the member or physician
- Excessive time and/or amount of Observation Services than are medically required by the condition of the member.
- Observation Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for Observation Services.

The following are not covered for the purpose of family planning services and supplies:

- Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility,
- Pregnancy termination counseling,
- Pregnancy terminations unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother;
- Hysterectomies for the purpose of sterilization.

Dental Services Coverage and Limitations

Molina's subcontractor to administer dental benefits for AHCCCS members in Arizona is DentaQuest. Each member under the age of 21 is assigned a dental home. The dental home provides comprehensive individualized evidence-based preventative care as outlined in the dental periodicity schedule, diagnostic services, radiological services, and restorative medically necessary therapeutic services. Orthodontic services and surgery are only covered when medically necessary and the primary treatment of choice. Cosmetic procedures are not covered.

Appropriate informed consents and treatment plans are required to be written, dated, and signed. These documents are to be maintained in member charts and are subject to audit.

Emergency dental services of $1,000 per Contract year are covered for AHCCCS members age 21 years and older. When treatment beyond the eligible benefit is anticipated and the provider intends to bill the member any outstanding amount, this must be disclosed in a document and signed by the member if the member agrees prior to services being rendered. The document is to describe the services to be provided and cost of the services.

Refer to the non-covered benefits for examples of emergency dental benefit limitations.

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

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

Injectable and Infusion Services

Many self-administered and office-administered injectable products require prior authorization. In some cases, they will be made available through a vendor that is designated by Molina. Additional information about our prior authorization process, including a link to the prior authorization request form, please refer to the Pharmacy section of this provider manual. Physician administered drug claims require the appropriate NDC number with the exception of vaccinations or other drugs as specified by CMS.

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

Access to Behavioral Health Services

Members in need of behavioral services can be referred by their PCP for services, or members can self-refer by calling Member Services at (800) 424-5891. Molina's Nurse Advice Line is available 24 hours a day, 7 days a week for mental health or substance abuse needs. The services members receive will be confidential. Additional detail regarding covered services and any limitations can be obtained in the summary of benefits linked above, or by contacting Molina.

Emergency Mental Health or Substance Abuse Services

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

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

Out of Area Emergencies

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

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

For out-of-area emergency services, plans will need 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 use of special equipment, life support systems and close monitoring by trained attendants while in route to the nearest appropriate facility, emergency transportation is required. Emergency transportation includes, but is not limited to, ambulance, air, or boat transports.

Non-Emergency Medical Transportation

Molina members receive non-emergent transportation services through the Molina non-emergency medical transportation network of providers. Contact Molina at (800) 424-5891 for additional information. Transportation assistance for trip recovery and after-hour discharges is available year-round, 24 hours a day, 7 days a week. Contact Molina at (800) 424-5891 (TTY: 711) and an on-call care coordinator or care manager will provide assistance. Please note: Non-emergency transportation after discharge requires a 3 business day notice. Members require prior authorization from Molina for ground and air ambulance services before the services are rendered. Prior authorization is not required for vans, taxi, etc., where they are covered benefits. Additional information regarding the availability of this benefit is available by contacting the Molina Provider Contact Center at (800) 424-5891 (TTY: 711).

Preventive Care

Preventive care guidelines are located online at MolinaHealthcare.com.

Providers can help by conducting these regular exams in order to meet the targeted state and federal standards. Please call our Health Education line at (800) 424-5891 (TTY: 711) with questions or suggestions related to well-child care.

Preventive Health and Wellness

Molina has developed numerous education, promotion, and outreach strategies. We continuously monitor the effectiveness of these strategies that encourage healthy behaviors. Molina ensures all members receive appropriate screenings, access to digital and mobile health apps and treatment, if needed. To promote self-care and personal responsibility, we offer member incentive programs that reward members for activities such as completing a preventive visit or health risk screening and assessment. By participating in these healthy behaviors, members can earn rewards that are loaded onto a Complete Care Counts reloadable debit card that can be used to purchase health-related services and supplies. To learn more, visit our website at MolinaHealthcare.com.

Providers can help by conducting these regular exams in order to meet the targeted state and federal standards. If you have questions or suggestions related to well childcare, please call our health education line at (800) 424-5891.

Immunizations

Adult members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP). Child and adolescent immunization recommendations are based on the CDC recommended childhood immunization schedules and as specified in AMPM Policy 310- M, according to age and health history.

Immunization schedule recommendations from the CDC and ACIP are available online at: Immunization Schedules | CDC, Advisory Committee on Immunization Practices (ACIP) | CDC

Providers are required to maintain the Arizona State Immunization Information System (ASIIS) registry of oral immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Chapter 135. Providers that service members under the age of nineteen (19) need to enroll and maintain yearly enrollment with Vaccines for Children (VFC) Program.

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

Well Child Visits and EPSDT Guidelines

The federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until twenty-one (21) years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and periodicity schedule follow the recommendations from the AAP and Bright Futures. Learn more at www.AZAHCCCS.gov.

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 Arizona recommended childhood immunization schedule, as appropriate
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Oral health screenings and dental services

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

We need your help conducting these regular exams to meet the AHCCCS- targeted state standard. Providers need to document all immunizations in the Arizona State Immunization Information System (ASIIS) monthly. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well childcare, please call our health education line at (800) 424-5891.or contact ADHS at 602–364-3642.

Prenatal Care

Stage of Pregnancy	How Often to See the Doctor
One month-six months	One visit a month
Seven months-Eight months	Two visits a month
Nine months	One visit a week

Well-Woman Preventative Care Services Provider Requirements

Provider requirements for well-woman preventive care services include the following:

- Covered services included as part of a well-woman preventive care visit:

An annual well-woman preventive care visit is intended for the identification of risk factors for disease, identification of existing physical/behavioral health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventive care visit is inclusive of a minimum of the following:
  o A physical exam (Well Exam) that assesses overall health Clinical Breast Exam
  o Pelvic exam (as necessary, according to current recommendations and best standards of practice)
  o Review and administration of immunizations, screenings, and testing as appropriate for age and risk factors as specified in AMPM Chapter 300
  o Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks and addressing at a minimum the following:
    - Proper nutrition
    - Physical activity
    - Elevated BMI indicative of obesity
    - Tobacco/substance use, abuse, and/or dependency
    - Depression screening
    - Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
    - Sexually transmitted infections
    - Human Immunodeficiency Virus (HIV)
    - Family Planning Services and Supplies, (refer to AMPM Policy 420)
    - Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
      - Reproductive history and sexual practices
      - Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
      - Physical activity or exercise
      - Oral health care
      - Chronic disease management
      - Emotional wellness
      - Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and
      - Recommended intervals between pregnancies, and
      - Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

Genetic screening and testing are not covered, except as specified in AMPM Policy 310-II.

There is no co-payment or other charge for women's preventative care visit as specified in ACOM Policy 431.

Members needing assistance scheduling preventative care appointments and medically necessary transportation may contact Molina Member Services for assistance.

Maternity/Family Planning Services

Family planning services and supplies, when provided by the appropriate family planning providers, are covered for members, regardless of gender, who voluntarily choose to delay or prevent pregnancy. Maternity care providers also provide family planning services and supplies within their training and scope of practice. Family planning services and supplies include covered medical, surgical, pharmacological, and laboratory benefits as well as contraceptive devices (including Intrauterine Devices (IUDs) and subdermal implantable contraceptives).

Members may choose to obtain family planning services and supplies from any appropriate provider regardless of whether the family planning service providers are network providers. Prior authorization is not required if services are provided by an out-of-network provider.

Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available.

Natural family planning education, post-coital emergency oral contraception, sterilization, and treatment of complications from family planning interventions. Consent provisions due apply to services involving sterilizations and consents provided to the Health Plan. Copies of consents can be located on the Molina Healthcare portal in the "Forms" section.

For non-covered services associated with family planning, reference the benefit limitations section and/or contract your provider representative to further assist with your inquiries.

A full continuum of maternity care services is covered for all eligible, enrolled members of childbearing age. This includes preconception counseling, pregnancy testing, prenatal care, medically necessary treatment of pregnancy related conditions, labor and delivery services, and postpartum care. Maternity and gynecology related services may be provided by qualified providers practicing (including licensed midwives) within the scope of their training and licensure and in compliance with the most current American College of Obstetricians and Gynecologists, (ACOG) standards for obstetrical and gynecological services. Maternity and gynecology related services may be provided by qualified providers practicing (including licensed midwives and Doulas) within the scope of their training and licensure and in compliance with the most current American College of Obstetricians and Gynecologists, (ACOG) standards for obstetrical and gynecological services.

While prior authorization of routine obstetrical care is not required, provider notification of member pregnancy to Molina Healthcare is required upon verification of pregnancy.

Notification forms are located are located on the Molina Healthcare provider website under "Forms" and are to be faxed to 888-656-7541 or emailed to MCCAZ- PregnancyTerm@MolinaHealthcare.com. All pregnant members are strongly encouraged to seek care within the first trimester of pregnancy. Molina Healthcare offers specialized care management services related to maternity. Referrals for care management can be made telephonically, by using the care management referral form located on the provider website (Molina Healthcare Care Management Program Referral Form and Instructions) or email to AZCMReferrals@MolinaHealthcare.com.

All cesarean sections are required to include medical documentation surrounding medical necessity. In addition, all inductions and cesarean sections done prior to 39 weeks are to follow the ACOG guidelines. Any inductions performed prior to 39 weeks or cesareans sections performed at any time that are found not to be medically necessary based on the nationally established criteria are not eligible for payment.

Except in case of medical emergencies, prior authorization is required for pregnancy terminations. Coverage for pregnancy terminations is conditional and based on AHCCCS directives. Written consent to termination by the member (age 18 or older) or HCDM if under the age of 18 or considered an incapacitated adult is required to be obtained and retained in the member's medical record. Medical review of pregnancy terminations are conducted by Molina. Additional information regarding coverage and limitations reference AMPM Policy 410 at AMPM Policy 410 (azahcccs.gov).

Instances resulting in a stillbirth/fetal demise prior to delivery require the submission of medical records for review. Medical record submission requirements include: 1) Provider's obstetrical prenatal records (History & Physical) including an Estimated Date of Confinement (EDC) or an ultrasound report when completed before 22 weeks gestation, 2) Maternal and newborn delivery records to confirm infant's weight, or gestational age, as well as the date/time of delivery and zero Apgar score, including results of syphilis testing.

Emergency Services

Emergency services means: Those health care services that are rendered by participating or non-participating providers after the sudden onset of 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: (1) placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

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

24-Hour Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven 7 days a week, 365 days a year.

Phone: (800) 424-5891 (TTY: 711)

Molina is committed to helping our members:

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

These registered nurses do not provide a diagnosis. 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 members to the PCP, a specialist, 911 or the emergency room. By educating patients, it reduces costs and overutilization of the health care system.

Health Management Programs

For additional information, please refer to the Health Care Services section of this provider manual.

Telehealth and Telemedicine Services

Molina members may obtain physical and behavioral health covered services by participating providers through the use of telehealth and telemedicine services. Not all participating providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a participating provider.
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Member cost sharing may apply based on the applicable benefits 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.

8. 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 CM 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 UM program include pre-service authorization review, inpatient authorization management that includes pre-admission, admission and concurrent medical necessity review and restrictions on the use of out-of-network or non-participating providers.

Utilization Management

Molina ensures the service delivered is medically necessary and demonstrates 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 UM program maintains flexibility to adapt to changes in the member's condition, and is designed to influence a member's care by:

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

Key Functions of the UM Program

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

- Eligibility and Oversight
    - o Eligibility verification
    - o Benefit administration and interpretation
    - o Verification that authorized care correlates to Member's medical necessity need(s) & benefit plan
    - o Verifying of current Physician/hospital contract status

- Resource Management
  - Prior Authorization and referral management
  - Admission, and Inpatient Review
  - Referrals for Discharge Planning and Care Transitions
  - Staff education on consistent application of UM functions
- Quality Management
  - Evaluate satisfaction 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/Medical Management Program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Molina of AZ's website or contact the HCS department by calling (800) 424-5891 (TTY: 711).

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 payment of request (adverse determination)

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 reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation in accordance with federal and state regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity criteria are reviewed by a designated Molina medical director. Only a physician who holds a non-restricted license in Arizona and has appropriate clinical knowledge in the same or similar specialty that typically manages the condition, procedure or treatment under review will render decisions to make an adverse determination for an authorization based on medical necessity, authorize a request in an amount, duration, or scope that is less than requested, or make a decision involving excluded or limited services.

Molina's use and interpretation of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions does not imply that the American Society of Addiction Medicine has either participated in or concurs with the disposition of a claim for benefits.

Providers can contact Molina's Health Care Services department at (800) 424-5891 (TTY: 711) to obtain Molina's UM criteria.

Medical Necessity

Medically necessary or medical necessity definition:

Medically Necessary-Per Arizona Medicaid, is a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life as specified in A.A.C. R9-22-101

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

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

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

The fact that a provider has prescribed, recommended, or approved medical or allied goods or services doesn't, by itself, make such care, goods or services medically necessary, a medical necessity or a covered service and/or benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Care 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 Care 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 Care 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 the primary submission route, for advanced

imaging requests. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

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

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

Medical Necessity Review

Molina only reimburses for services that are medically necessary. Medical necessity review may take place prospectively as part of a pre-service request, concurrently 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, Molina clinical policies, guidelines from recognized professional societies and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or participating provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to an administrative or medical necessity adverse determination are reviewed by a Molina Medical Director.

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 and review. Clinical information includes but is not limited to:

- Physician emergency department notes
- Inpatient history/physical exams
- Pro-active discharge planning
- Discharge summaries
- Physician progress notes
- Physician office notes
- Physician orders
- Nursing notes
- Results of laboratory or imaging studies
- Therapy evaluations and therapist notes

Prior Authorization

Molina requires prior authorization for specified services, as long as the requirement complies with federal or state regulations and per the Provider Services Agreement with Molina. The list of services that require prior authorization is available on the Prior Auth LookUp Tool via the Molina of AZ Website. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com.

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

- Member demographic information (name, date of birth, Molina (AHCCCS) 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 and/or procedure, including all appropriate CPT and HCPCS codes
- Physical location where service(s) will be performed
- Clinical information sufficient enough to document the medical necessity of the requested service is required, including but not limited to:
    o Pertinent medical history (include treatment, diagnostic tests, and examination data)
    o Requested length of stay (applicable for inpatient requests)
    o Rationale for expedited processing. Expedited requests must meet the state definition or may be downgraded to standard requests per state requirements.

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

Molina follows all prior authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMHPA).

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 unless extenuating circumstances are present and provided with the authorization request. An extenuating circumstance is defined as: Provider did not know nor reasonably could have known the patient was a Molina member at the time service was rendered, or the Provider did not know nor reasonably could have known that the patient needed a service that required authorization prior to the service being rendered, or Molina error, or Special Provider contractual requirements. Retro- authorization with extenuating circumstances can be evaluated by the UM Dept when the request is received within ten (10) business days of the provider becoming aware of the extenuating circumstance.

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 any request for medical or behavioral health care or services with respect to which the application of time periods for non-urgent care determinations could seriously jeopardize the life, health, or safety of

the member or others or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain or other adverse health consequences that cannot be adequately managed without the care or treatment that is the subject of the request. Supporting documentation is required to justify the expedited/urgent request.

Molina will make an organizational determination as promptly as the member's health requires, and no later than 72 hours after we receive the initial request for service in the event a provider indicates, or if we determine that a standard authorization decision time frame could jeopardize a member's life or health. For a standard authorization request, Molina makes the determination and provides notification within fourteen (14) calendar days.

Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina medical director is available to discuss medical necessity decisions with the requesting provider. To speak to our medical director, please call (800) 424-5891.

Upon approval, the requester will receive an authorization number. The number may be provided by telephone, fax, or the Availity Essentials portal. If a request is denied, the requester and the member will receive a letter explaining the reason for the denial along with additional information regarding the grievance and appeals process and peer-to-peer information as applicable. Providers may receive notifications or denials via fax or the Availity Essentials portal.

Physical Health Turn-Around-Times:

Authorization	Priority	Turn Around Time
Outpatient	Standard Pre-Service	**No later than 14 Calendar Days from the date the request was received**
Outpatient	Urgent Pre-Service	**No later than 72 hours from the date the request was received OR as expeditiously as the Member's condition requires**
Outpatient Extension	Extension- Urgent Pre-Service	**An additional 14 Calendar Days can be granted except for Specialty Medications- From the date the NOE is issued**
Inpatient Initial (Admission)	Urgent Concurrent	**No later than 1 Business Day from receipt of the request.**
Inpatient Subsequent (Concurrent) Continued Stay	Urgent Concurrent	**No later than 1 Business Day from receipt of the request.**

Behavioral Health Turn-Around-Times:

Authorization	Priority	Turn Around Time
Outpatient Residential- Mental Health Residential- SUD (substance use disorder)	Urgent	**No later than 72 hours from the date the request was received OR as expeditiously as the Member's condition requires**
Outpatient Extension	Extension- Urgent	**An additional 14 Calendar Days can be granted from the date the NOE issued**
Inpatient Initial (Admission) Behavioral Health IDM IP-Detox IP-SUD IP-MH	Urgent Concurrent	**No later than 1 Business Day from receipt of the request.**
Inpatient Subsequent (Concurrent) Continued Stay Behavioral Health IDM IP-Detox IP-SUDIP-MH	Urgent Concurrent	**No later than 1 Business Day from receipt of the request.**
Retrospective	Retro	**No later than 14 Calendar Days from receipt of the request**
IOP- intensive outpatient	**No auth/UM review required for the first 16 units unless OON**	

Requesting Prior Authorization

Notwithstanding any provision in the provider agreement that requires providers 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 online at MolinaHealthcare.com:

- Prior authorization code look-up tool
- Prior authorization guide

Peer-to-Peer Review

A provider requesting authorization of a service may request a peer-to-peer discussion with a Molina Medical Director during the authorization process and/or after receipt of an adverse determination. In the event an adverse benefit notification is received, a formal appeal will need to be initiated for reconsideration of the original decision. More information regarding the processes and timelines after receipt of an adverse determination can be found in the Member Grievances and Appeals section of this manual. A "peer" is considered the Member's or Provider's clinical representative (licensed medical professional) Contracted external parties, administrators, or facility UM staff can only request that a peer-to-peer telephone communication be arranged and performed but the discussion should be performed by a peer.

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 (2) business days. Every effort will be made to return calls as expeditiously as possible.

- **Availity Essentials Portal:** Molina is transitioning to a portal-only submission model, and phone or fax-based submissions may be phased out in certain markets. Participating Providers should use the Availity Essentials portal for prior authorization submissions. All prior authorization submissions must include supporting clinical documentation to ensure timely and accurate review. 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: Creating and submitting prior authorization requests
- Checking the status of prior authorization requests
- Receiving notification of changes in status of prior authorization requests
- Attaching medical documentation required for timely medical review and decision-making
- Receive notification of authorization decisions
- Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.

Fax: The prior authorization request form can be faxed to Molina at (888) 656-7501.

Inpatient requests/clinical can be faxed to Molina at (888) 656-2201.

Phone: Prior authorizations can be initiated by calling Molina at (800) 424-5891 (TTY: 711). It may be necessary to submit additional documentation before the authorization can be processed.

Emergency Services: Those health care services that are rendered by participating or non-participating providers after the sudden onset of 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: (1) placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

Emergency medical condition or emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Examples include but are not limited to:

- Serious burns
- Car accident
- Poisoning
- Overdose
- Sudden chest pains, including heart attack
- Convulsions
- Seizures
- Broken bones
- Trouble breathing
- Extreme bleeding

A medical screening exam performed by licensed medical personnel in the emergency room 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.

Members overutilizing the emergency room will be contacted by Molina care managers to provide assistance whenever possible and determine the reason for using emergency services.

Care managers will also contact the PCP to ensure that members are not accessing the emergency room because of an inability to be seen by their PCP.

Appropriate and non-appropriate use of the emergency department

Molina contracts with providers for all levels of care to have the right service available at the right time to meet a member's needs. Education is available and offered to members seeking care at the emergency department for treatment of conditions that could safely be provided at a different level of care.

Examples of non-emergent symptoms include:

- Minor burns
- Earache or ear infection
- Pink eye
- Sore throats
- Rashes and/or mild skin infections
- Gastrointestinal illness including mild dehydration due to vomiting and/or diarrhea

Inpatient Management

Post stabilization care services are covered medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized to maintain, improve, or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location. Requests for authorization of services need to be called into Molina at (800) 424-5891 in addition to the standard process of providing clinical documentation.

Planned Admissions

Molina requires prior authorization for all elective and/or scheduled/planned inpatient admissions and procedures to any facility. Facilities are required to notify Molina within 24 hours, or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment. Molina will review the medical necessity for continued stay, clinical is due within twenty-four (24) hours or the following business day from when the next review date is set or from the last authorized day. In the event continued stay is denied, Molina will continue to work with the provider/facility to ensure safe discharge plan, coordination of care, and transition. Facilities are required to provide discharge plan with twenty-four (24) hours or the following business day of Molina's request. Discharge date and disposition including discharge summary is due within twenty-four (24) hours or the following business day of discharge.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission, or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC) and initiate concurrent review and discharge planning. Molina requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay. Molina will review the medical necessity for continued stay, clinical is due within 24 hours or the following business day from when the next review date is set or from the last authorized day. In the event continued stay is denied, Molina will continue to work with the provider/facility to ensure safe discharge plan, coordination of care, and transition. Facilities are required to provide discharge plan with 24hrs or the following business day of Molina's request. Discharge date and disposition including discharge summary is due within 24 hours or the following business day of discharge.

Inpatient at time of Termination of Coverage

When a member's coverage with Molina terminates during a hospital stay, Molina will continue to cover services through discharge, unless Law or Government Program requirements mandate otherwise.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from facilities, including Behavioral Health Residential Facilities (BHRF). Molina will request updated clinical records from facilities at regular intervals during a member's stay. Molina requires that requested clinical information updates be received by Molina from the facility within 24 hours or the following business day of the request. In the event of a denial, Molina will continue to work with the provider/ facility to ensure safe discharge plan, coordination of care, and transition. Facilities are required to provide discharge plan with twenty-four (24) hours or the following business day of Molina's request. Discharge date and disposition including discharge summary is due within twenty-four (24) hours or the following business day of discharge.

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

Molina will authorize care when the clinical record supports the medical necessity for the need for continued 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, instructions, and disposition regardless of if stay was approved or denied and within 24hrs or next business day from the date of discharge.

Inpatient Status Determinations

Molina's UM staff follow the clinical hierarchy 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. Discharge planning should begin on admission, continue throughout stay and facilitate a seamless transition post discharge. Facilities are required to provide discharge plan with 24hrs or the following business day of Molina's request. Discharge date and disposition including discharge summary is due within 24 hours or the following business day of discharge. HCS staff work closely with the provider, facility, and/or discharge planners to determine the most appropriate discharge setting for our members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Molina's quality improvement program to ensure that Molina members are receiving 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 72 hours 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 (Retrospective) Review

Failure to obtain authorization when required will result in denial of payment for those services, unless extenuating circumstances were present, and proof of extenuating circumstances are submitted with the request. An extenuating circumstance is defined as: Provider did not know nor reasonably could have known the patient was a Molina member at the time service was rendered, or the Provider did not know nor reasonably could have known that the patient needed a service that required authorization prior to the service being rendered, or Molina error, or Special Provider contractual requirements. Retro- authorization with extenuating circumstances can evaluated by the UM Dept when the request is received within ten (10) business days of the provider becoming aware of the extenuating circumstance. 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.

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 or behavioral health 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. 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 receive prior authorization from Molina. Non-network providers may provide emergency services for a member who is temporarily outside the service area without prior authorization or as otherwise required by federal or state laws or regulations.

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

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

Molina staff provide an integrated approach to care needs by assisting members with identification of resources available to the members, 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.

Molina maintains formal collaborative protocols and Memorandums of Understanding (MOUs) with select governmental agencies. These partnerships are structured through clearly defined agreements that guide joint initiatives and responsibilities. All relevant documentation, including protocols and MOUs, is accessible through the Availity Essentials portal continuity of care and transition of members.

It is Molina's policy to provide members with advanced 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. The out-of-network provider can provide continued services to members undergoing a course of treatment after they have terminated their contractual agreement if the following conditions exist at the time of termination:

- **Acute condition or serious chronic condition-** Following termination, the terminated provider will continue to provide covered services to the member for up to 90 days or longer if necessary for a safe transfer to another provider as determined by Molina or its delegated medical group/IPA.
- **High risk of second or third trimester pregnancy-** The terminated provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

For additional information regarding continuity of care and transition of members, please contact Molina at (800) 424-5891 (TTY: 711).

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 need community care services by reason of mental or other disability, age, or illness; and who is or may be unable to take care of themself, or unable to protect themself against significant harm or exploitation. When working with children, one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. It is Molina's expectation that all providers have a duty to warn and/or report abuse as specified in AMPM Policy 961. Specific professionals mentioned under the law as mandated reporters are:

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

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

Child Abuse

Arizona Department of Child Safety (888) 767-2445

Adult Abuse

Arizona Adult Protective Services (877) 767-2385

Molina's HCS teams will work with PCPs, medical groups/IPAs, and other delegated entities who are obligated to communicate with each other when there's 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 care manager provides the PCP with the member's Individualized Care Plan (ICP), Care team updates and information regarding the member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Care Manager Responsibilities

The care manager collaborates with the member and any additional participants as directed by the member to develop an ICP that includes recommended interventions from member's care team, 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 healthcare 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 care team as member needs warrant
- Serves as a coordinator and resource to the member, their representative and care team participants throughout the implementation of the ICP and revises the plan as suggested and needed
- Coordinates appropriate education and encourages the member's role in self- management
- Monitors progress toward the member's achievement of ICP goals to determine an appropriate time for the member's graduation from the CM program

Health Management

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

Level 1 Health Management

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

The chronic conditions programs include:

- Asthma
- Depression
- Diabetes
- COPD
- Heart Failure
- Hypertension

Molina healthy lifestyle programs include:

- Weight Management
- Tobacco Cessation
- Nutrition consult

For more information about these programs, please call (833) 269-7830 (main line) or (866) 472-9483 (health lifestyle programs), TTY/TDD: 711 or fax at (800) 642-3691.

Maternity Screening and High-Risk Obstetrics

Molina offers prenatal health education to all pregnant members 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 12th week post-delivery. Pregnant member outreach, screening, education, and care management are initiated by provider notification to Molina, member self-referral and internal Molina notification processes. Providers can notify Molina of pregnant/ high risk pregnant members via faxed Pregnancy Notification Report Forms.

Pregnancy notification process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (888) 656-0369.

Member Newsletters

Member newsletters are posted online at MolinaHealthcare.com twice a year. The article topics are based on questions 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 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 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 with 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 the Nurse Advice Line, medication management or UM.
- Member self-referral due to general plan promotion of the program through the 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 HM programs, including how to enroll patients and outcomes of the programs
- Clinical practice guidelines
- Preventive health guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on the HM programs is available from Molina toll free at (800) 424- 5891.

Primary Care Providers

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

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

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

Out of State Placements

In the event of an out -of- state placement, Molina Healthcare will first ensure that the member's needs are met and then focus on finding in-state solutions for the member for either a single case agreement or a contract. If in-network and in-state options are not available, Molina Healthcare will investigate out-of-state treatment options and follow the guidance in AMPM Policy. For behavioral health care services, the Child and Family Team (CFT), Adult Recovery Team (ART), TRBHA, or FFS provider will review all other relative in- state provider options, including use of single case agreements with an in-state provider before the medical director makes the decision for out of state placement.

Services provided Out-of-State shall meet the same requirements as those rendered in state. Molina Healthcare ensures that Out-of-State providers follow all AHCCCS reporting requirements, policies, and procedures, including appointment standards and timelines specified in ACOM Policy 417. Out-of-State placement providers are required to coordinate with Molina Healthcare to provide the required information.

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 care management (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
- High-technology home care requiring more than two weeks of treatment
- Member accessing emergency department services inappropriately
- Children with special health care needs

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

Phone: (800) 424-5891
Fax: (888) 656-0369
Email   AZCMReferrals@MolinaHealthcare.com

9. BEHAVIORAL HEALTH

Overview

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

Behavioral Health Providers

Behavioral Health Residential Facility (BHRF)

Molina requires all provider practices align with the secured BHFR requirements and adhere to provider requirements as specified in AMPM 320 V. Standards for services provided to Molina members are not to be deficient of any of the expectations outlined in AMPM 320 V for FFS members.

Adult Behavioral Health Therapeutic Homes (ABHTH)

Molina requires all providers to adhere to AMPM 320 X as well as procedure requirements as specified in A.A.C. R9-10-1801 et. Seq and the Arizona State Plan for Medicaid.

Utilization Management and Prior Authorization

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

Some behavioral health services may require prior authorization.

Behavioral health inpatient, substance use disorder residential services, psychiatric residential treatment, and select outpatient treatment(s) can be requested by submitting a Prior Authorization form or contacting Molina's prior authorization team at (800) 424-5891. Molina strongly recommends the use of the Availity Essentials portal to submit ALL prior auth requests.

Emergency psychiatric services do not require Prior Authorization. All requests for behavioral health services should include the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification as well as current clinical information supporting the request Molina utilizes standard, generally accepted Medical Necessity criteria for prior authorization reviews.

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

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network behavioral health Provider via referral from a PCP, medical specialist or by member self-referral. PCPs may screen and assess members for the detection and treatment of any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health service within the scope of their practice and

in compliance with all state and regulatory requirements for the service provision. A formal referral form or prior authorization is not needed for a member to self-refer or be referred to a PCP, specialist or behavioral health provider. However, individual services provided by non-network behavioral health providers will require prior authorization.

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

Care Coordination and Continuity of Care

Discharge Planning

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

Interdisciplinary Care Coordination

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

Care Management

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

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

Phone: (800) 424-5891 (TTY: 711)
Fax: (888) 656-0369
Email: AZCMReferrals@molinahealthcare.com

For additional information on the care management program, please refer to the Care Management subsection found in the Health Care Services section of this Provider Manual.

Behavioral Health Care Management

Access to Records and Information to Support Member Care Coordination and Care Management Activities

Molina is committed to working with its Providers to address the care coordination and care management needs of its members. To facilitate such activities, all Providers (including substance

use disorder providers and behavioral health providers) are required to cooperate with and provide to Molina any and all relevant patient/member records and information requested by Molina to support such activities. To the extent a consent and/or authorization from the patient/member is required by law to disclose the requested records/information to Molina, the Provider shall make best efforts to obtain the necessary consent(s) and/or authorization(s) from the patient/member. Both Molina and the Provider agree to comply with HIPAA and other applicable federal and state privacy laws and regulations including, but not limited to, the HIPAA privacy regulations set forth in 45 C.F.R. Part 164 Subpart E, the HIPAA security regulations set forth in 45 C.F.R. Part 164 Subpart C, 42 C.F.R. Part 2 Regulations governing the Confidentiality of Substance Use Disorder Patient Records and state-specific medical privacy laws.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of both physical and behavioral health services to provide quality care coordination to members. Behavioral health Providers are expected to provide in-scope, evidence-based mental health and substance use disorder services to Molina members. Behavioral health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow quality standards related to access. Molina provides oversight of Providers to ensure members can obtain needed health services within acceptable appointment timeframes. Please refer to the Quality section of this Provider Manual for specific access to appointment details.

All members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The after-care 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 twenty-four 24 hours of a missed appointment to reschedule.

Molina monitors that an effective referral and intake process is in place for behavioral health services to ensure member's access to behavioral health services in a timely manner. Referrals are accepted for behavioral health services 24 hours a day, seven days a week. The processing of referrals shall not be delayed due to missing or incomplete information. An acknowledgement of receipt of a referral shall be provided to the referring entity within 72 hours from the date it was received.

Behavioral Health providers will conduct intakes ensuring the accurate collection of all the required information and ensure that members who have difficulty communicating because of a disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs. Behavioral Health Providers must approach the member and family in a strength-based manner and possess a clear understanding of the information that needs to be collected. The Behavioral Health providers will determine the urgency of the situation and subsequently schedule an assessment within the required timeframes and with an appropriate provider.

Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program. For individuals who are not currently Title XIX/XXI eligible, a financial and eligibility screening and application shall be completed to determine eligibility. Behavioral health providers are required to assist individuals in completing this process. To conduct

the AHCCCS screening/application for Title XIX/XXI or other Public Program eligibility through HEAPlus, behavioral health providers shall meet with the individual and complete the AHCCCS HEAPlus online application.

If the individual needs emergency services, the individual may begin to receive these services immediately provided that within five days from the date of service a financial screening is initiated.

Behavioral health providers shall offer and provide assistance with completing Medicare Part D enrollment to individuals who are Medicare-eligible.

When an individual declines to participate in the AHCCCS screening/application process or refuses to enroll in a Medicare Part D plan, the provider shall actively encourage the individual to participate in the AHCCCS screening/application process. The provider shall inform the individual who they can contact in the behavioral health system for an appointment if the individual chooses to participate in the AHCCCS screening/application process in the future.

Serious Mental Illness (SMI)

It is the policy of Molina to ensure members who may qualify for Serious Mental Illness (SMI) designation are promptly identified and enrolled for services. AHCCCS has developed a standardized process for the referral, evaluation, and determination of SMI eligibility. The SMI eligibility evaluation record must contain all the documentation that was considered during the review including, but not limited to current and/or historical treatment records. Molina makes available to providers any requirements or guidance on SMI eligibility evaluation record location and/or maintenance.

The provider or the AHCCCS Complete Care Contractor with Regional Behavioral Health Agreement completes an evaluation and a SMI Assessment packet. The packet is then sent to Solari. Solari reviews all requests for SMI determinations. Solari will decide if the person is eligible to be designated as having SMI. Solari uses State guidelines and criteria, for more information go to: https://community.solari-inc.org/eligibility-and-care-services/

Upon a provider's receipt of a member's referral, a request, or identification of the need for an SMI Eligibility Determination, the provider or provider's staff member must schedule an assessment if one has not been completed within the last six months. This shall occur as expeditiously as the member's health condition requires, but no later than seven (7) business days after receiving the request or referral. When determination requests are made for members who are currently admitted to a hospital for psychiatric reasons, the evaluation shall ensure that documented efforts are made to schedule a face-to-face assessment with the member while the member is hospitalized.

The final determination of SMI eligibility requires both a qualifying SMI diagnosis and evidence of functional impairment that is a direct result of the qualifying diagnosis (see https://www.azahcccs. gov/PlansProviders/MedicalCodingResources for a list of qualifying diagnoses).

Molina Healthcare members, who are subsequently determined to have a SMI, will be transitioned to an ACC-RBHA to receive both physical and behavioral health services. Members have the option to remain with Molina to receive ongoing physical health services. In accordance with ACOM Policy 402, Molina will receive enrollment notification from AHCCCS regarding the change of eligibility and will begin the transition process.

Serious Emotional Disturbance (SED)

It is the policy of Molina to ensure members up to the age of 18 who may qualify for a Serious Emotional Disturbance (SED) identification are promptly identified and enrolled for services. Upon a provider's receipt of a member's referral, a request, or identification of the need for SED Identification, the provider or provider's staff member must schedule an assessment if one has not been completed within the last six months. This shall occur as expeditiously as the member's health condition requires, but no later than seven (7) business days after receiving the request or referral. AHCCCS has developed a standardized process for the referral and identification of eligible members which is outlined in the AHCCCS Serious Emotional Disturbance Identification FAQs found on the AHCCCS website. Molina Healthcare members, who are subsequently identifed to have a SED, will remain with Molina Healthcare to receive both physical and behavioral health services. However, if the member no longer qualifies for coverage under Molina Healthcare, the member may be eligible to continue to receive covered behavioral services through Mental Health Block Grant (MHBG) funding from the ACC-RBHA as outlined in AMPM Exhibit 300-2B.

Outreach, Engagement, and Re-Engagement for Behavioral Health

Outreach

Molina participates in various community events and activities to educate the public about our plan and health related information. Molina encourages our providers to participate in these outreach activities wherever possible.

Engagement

Providers will engage in active treatment planning processes by including the following:

1. The Member and/or Health Care Decision Maker (HCDM) or Designated Representative (DR)
2. The Member's family
3. Other agencies and/or providers as applicable

Re-engagement

Behavioral Health providers shall attempt to re-engage the Member including, but not limited to, the following actions that are documented in the members' comprehensive medical record:

1. Communicating in the Member's preferred language and in a culturally competent manner
2. Contacting the Member and/or Health Care Decision Maker or Designated Representative by telephone, face-to-face or sending a letter
3. Contacting the member and/or HCDM, DR at times when the member is reasonably expected to be available (e.g. after work or after school)

If the outreach is successful and the Member appears to be a danger to them self, danger to others or is acutely or gravely disabled, the provider shall determine whether it is appropriate to engage the Member to seek inpatient care voluntarily. If the member declines voluntary admission, the provider shall initiate the pre-petition screening or petition for treatment process specified in AMPM Policy 320-U.

Molina Healthcare's Care Management department also has an outreach and unable to contact protocol to follow for re-engagement activities. The Care Management department will collaborate with providers and make every attempt possible to re-engage members in their treatment plan.

Behavioral Health Crisis Line

Molina has a Behavioral Health Crisis Line that may be accessed by members 24/7 year- round. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling (800) 424- 5891.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone with concerns about someone else), can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

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

Court Order Evaluation (COE)/Court Ordered Treatment (COT):

Arizona counties are responsible for managing, providing, and paying for Pre-Petition Screening and Court Ordered Evaluation (COE) unless they have an Intergovernmental Agreement (IGA) with the Regional Behavioral Health Authority (ACC-RBHA) or another agency for the management of these funds. Any individual may submit an application requesting an agency to conduct a prepetition screening when another individual is alleged to be, as a result of a Mental Disorder: Danger to Self (DTS), Danger to Others (DTO), Persistently or Acutely Disabled (PAD), or Gravely Disabled (GD).

Pre-Petition Screening includes an examination of the member's mental health status and/or other relevant circumstances. The licensing Screening Agency's medical director or designee will determine if the member meets criteria for DTS, DTO, PAD or GD. The screening must take place within 48 hours excluding weekends and holidays. If the screening agency believes the member may be DTS, DTO, PAD or GD, the Screening Agency will file an Application for Emergency Admission for COE, as specified in A.R.S. §36-524. The Pre- Petition Screening Agency will offer assistance to the applicant through the involuntary application process.

For those providers, specialists, members, or family members seeking more information on the Court Ordered Evaluation or Court Ordered Treatment process, please utilize the below resources for additional information or they may contact Molina at (800) 424- 5891 (TTY: 711) and request a care manager.

- www.disabilityrightsaz.org
- www.maricopa.gov/5220/Steps-in-the-mental-health-evaluation-pr
- https://www.azahcccs.gov/shared/Downloads/COE-COT_FAQ.pdf
- https://azcourtcare.org/

Children's Integrated System of Care

Children ages 6-17 with a CALCOUS level of 4, 5, or 6 and children ages 0-5 who have experienced two or more of the following are eligible for High Need Case Management (HNCM) services:

    a. Other agency involvement including but not limited to Arizona Department of Child Safety, Arizona Early Intervention Program , Special Education or Division of Developmental Disabilities

    b. Out-of-home placement for behavioral health treatment within the past 6 months

    c. Psychotropic medication utilization

    d. Evidence of severe psycho-social stressors (e.g, severe primary caregiver stress, family member serious illness, disability, death, job loss, eviction)

High Needs Case Management focuses on providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. High Needs Case Managers must adhere to the ratio and contact requirements as outlined in AMPM 570 and AMPM 570 Attachment A. High Needs Case Managers should not be assigned duties unrelated to member's specific case management for more than 10% of their time when they have a full caseload.

Child and Adolescent Level of Care Utilization System (CALOCUS) and the Child and Adolescent Service Intensity Instrument (CASII).

The CALOCUS is a "standardized assessment tool that provides determination of the appropriate intensity of services needed by a child or adolescent and their family, and guides provision of ongoing service planning and treatment outcome monitoring in all clinical and community-based settings.

1. CALOCUS meets definitional criteria as a tool under contract and policy
2. Utilize the AHCCCS website for general resources, including the Medical Coding Resources, Billing Health Services Matrix, Claims Clues, AMPM 320-O, AMPM 570, and the current contract, and
3. Utilize national references such as CPT Manual.

AHCCCS began requiring the CALOCUS on July 1, 2021, to determine level of care for children 6-18 years of age. AHCCCS FAQ- CALOCUS. As of January 2025, the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) have partnered on the CALOCUS-CASII. As a result of this partnership, all training of the CALOCUS will be done by AACAP. AHCCCS has contracted with AACAP for the new online self-paced training and will be covering the cost for providers to be trained in CALOCUS.

Provider Agency Requirements: Employees who have been identified to complete the CALOCUS-CASII assessments are required to participate in AHCCCS-designated CALOCUS training and complete the training prior to the administration of the CALOCUS, as outlined in AMPM 580 F.

CALOCUS scores must be included in the member's medical record to minimize duplication of the CALOCUS. If the CALOCUS is completed by anyone other than the member's primary behavioral health provider, the completing provider shall share the results with the member's primary behavioral health provider(s), as applicable. All treating providers are expected to collaborate to address differences in CALOCUS levels at the clinical level and through the CFT, if applicable.

Relias Instructions

1. Enroll employees who are required to complete the CALOCUS-CASII training in the CALOCUS-CASII Training Plan in Relias named *AWFDA – CALOCUS-CASII Completion Certificate Requirement.
   a. Enrolling employees in the training plan will automatically enroll them in the Requirements Tracker.
2. Once the employee has completed the CALOCUS-CASII training through AACAP, the provider agency's supervisor/administrator will mark them complete and upload their certificate in the Relias *AWFDA – CALOCUS-CASII Completion Certificate Requirement Requirements Tracker.

Training hosted by AACAP can be accessed using the following steps:

Registering/Entering the Promo Code for the course:

1. Access AACAP's online store to view available training courses: www.aacap.org/store-onlineEC
2. Select the desired course "CALOCUS-CASII" and click on the "Add to Cart" button.
3. Click on the "Proceed to Checkout" button.
4. Existing AACAP account holders: Log in using AACAP account username and password credentials.
   a. New AACAP Users: Create an AACAP account profile, including username and password, by clicking" Create a new account."
5. When checking out, enter the promotional code AHCCCSFREE and click apply, which will provide a 100% discount.

Accessing the course:

1. Access AACAP's learning management system, "Pathways": www.aacap.org/pathways
2. Select "Access Your Courses"
3. Log in using your established credentials from your purchase.
4. Your course(s) will be listed on the left side of the screen.

For any questions or issues relating to login or clinical content, please reach out to clinical@aacap.org

The new CALOCUS training will take approximately 6 hours to complete. The learner will receive

a certificate following successful completion of the course. This certificate of completion will be uploaded into RELIAS to receive training credit. *An additional note for consideration: At this time AHCCCS will not be covering the cost of the LOCUS training.

Conducting the CALOCUS- CASII Assessment: There are two options for employees to complete the CALOCUS-CASII Assessment. Agencies must decide which option best aligns with their organizational needs

1. Deerfield/AHCCCS Portal: The CALOCUS assessment tool is completed with the Deerfield/AHCCCS Portal
   a. See the CALOCUS FAQ Section AHCCCS/DEERFIELD PORTAL & EHR Q1 for detailed instructions

2. EHR Integration of CALOCUS
   a. See the CALOCUS FAQ Section AHCCCS/DEERFIELD PORTAL & EHR Q3-4 for detailed instructions

Training Monitoring Process

Molina Healthcare will monitor the CALOCUS-CASII training requirements as outlined in AMPM 580 F. This monitoring process is essential to ensure compliance with the AHCCCS requirements and maintain fidelity to the established guidelines.

Behavioral Health Services for School-Aged Children

Molina Healthcare understands the importance of mental health, especially for school-aged children. Molina works collaboratively with both school districts and our contracted behavioral health providers to ensure school districts are able to meet the needs of their students.

All contracted outpatient behavioral health providers are required to accept the AHCCCS Schoolbased Universal Referral Form when students are referred for services. Additionally, all providers must communicate back to school districts in situations where students are transferred to other agencies due to capacity issues.

Providers can contact Molina Healthcare's System of Care department for assistance with removing barriers to referral pathways and improving access to care in school settings at mccazsystemofcare@ molinahealthcare.com

10. WORKFORCE DEVELOPMENT

Molina Healthcare Workforce Development implements, monitors, and regulates Provider WFD activities and requirements. In addition, Molina Healthcare evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable, and competent workforce.

In collaboration with AHCCCS, Molina Healthcare ensures that all course content is culturally appropriate, has a trauma-informed approach, and is developed using adult-learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements, and the requirements of several agencies, entities, and legal agreements.

The objective of Workforce Development Planning is to foster collaboration with internal stakeholders to ensure that members receive services from a sustainable workforce that is qualified, competent, and adequately staffed, as outlined in AHCCCS Policy ACOM 407.

A sustainable workforce plays a crucial role in establishing and maintaining the continuity of care for members. The approach to Workforce Development is rooted in a comprehensive, systematic, and measurable structure that incorporates best practices at all levels of service delivery. It embraces Adult/Children's Guiding Principles, Adult Learning Theories/Methods, Trauma-informed Care, Equitable Services, and Culturally Competent practices.

Providers are encouraged to continually assess their progress and adapt strategies to ensure the ongoing success and effectiveness of Workforce Development initiatives. The ultimate goal is to foster continuous growth and improvement within the organization, ensuring the delivery of high-quality services to members.

Training/Compliance Requirements

Relias Learning Management System (LMS) : Employees who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the Arizona Workforce Development Coalition (AWFDC) Training. This includes, but is not limited to, full time/part time/on-call, direct care, clinical, medical, administrative, leadership, executive and support employees.

Deliverables by Provider type:
https://www.azahp.org/awfdc

Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

To request access to Relias, please contact the Molina Healthcare Workforce Development Administrator for further assistance. The request should include the following information:

- Provider Agency Name
- Contract Start Date
- Address
- Key WFD Contact

- o Name
- o Phone Number
- o Email Address
- Contract Type (ACC, ACC-RBHA)
- AHCCCS Provider Type: (i.e. 77 Behavioral Health Outpatient Clinic)
- Number of Users (# employees at the agency who need Relias access)
- List of Health Plans provider is contracted with (if known)

Applicable provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of $1500 for full-site privileges. A full site is defined as a site in which the agency may have full control of course customizations and competency development.

Provider agencies with 19 or fewer users will be added to the AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited site is defined as one in which the courses and competencies are set up according to the standard of the plan with no customization or course development provided. Contact workforce@azahp.org to do so.

Provider agencies that expand to 20 or more users will be required to purchase full site privileges to Relias Learning immediately upon expansion.

* Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.

AWFDA Core Training Plans AWFDA–
Initial Training Plan (90 Days)

The Training Plan below is set to auto-enroll all NEW Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile. If the employee hired has a previous account under another agency, please ensure that you have their transcripts transferred (there is a job aid available at Training & Resources | AzAHP).

Initial Training Plan

- * AWFDA – AHCCCS 101 (2.0hrs)
- * AWFDA – Cultural Competency in Health Care (1.0 hrs)
- * AWFDA – Preventing and Reporting Fraud, Waste & Abuse (FWA) (0.5 hrs)
- * AWFDA – Quality of Care Concern (1.0hr)
- * AHCCCS – NEO – Member Employment Services (0.5 hrs)
Basics of Corporate Compliance (0.5 hrs)
HIPAA: Basics (0.5)
Integrated Approach to Primary and Behavioral Healthcare (1.0 hrs) Supporting Client Rights for Paraprofessionals in Behavioral Health (1 hr)

AWFDA—Core Training Plan (Annual)

The Training Plan below is set to auto-enroll all Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile.
RapidReg: HIPAA (0.15 hrs) – Due: January 31st
Abuse: Preventing, Recognizing, and Reporting (0.5 hrs) – Due: April 30th
RapidReg: Corporate Compliance (0.2 hrs) – Due: May 31st

*AWFDA – Cultural Competency in Health Care (1.0 hrs) – Due: July 31st
*AWFDA – Preventing and Reporting Fraud, Waste & Abuse (FWA) (0.5 hrs) – Due: Oct. 31st
*AWFDA – Quality of Care Concern (1.0 hr) – Due: December 31st
*AHCCCS – Health Plan Fraud (0.75 hrs) Due: October 31st

Quarterly Reports

The ACC-AWFDA will run Quarterly Learner/Course Status Reports on the two AWFDA Training Plans: *AWFDA – Core Training Plan (90 Days) & *AWFDA – Core Training Plan (Annual). The goal for Providers is to hold a 90% (or higher) completion rate for this group of courses, within the specified reporting period.

Provider agencies that fall at 75% or below on the above completion reports will be required to have at least 1 Relias Administrator/Supervisor from their agency complete the course titled: *AzAHP – Navigating & Managing Your Relias Portal

Provider agencies falling below 90% on the above completion reports may be subject to corrective action and/or sanctions (including suspension, fines, or termination of contract) by their contracting Health Plan(s).

11. OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS (OIFA)

Peer and Recovery Support Specialists

The Office of Individual and Family Affairs (OIFA) Alliance has developed training requirements and certification standards for Peer and Recovery Support Specialists (PRSS) providing Peer Support Services, as described in the AMPM Policy 963. Peers serve an important role as providers within AHCCCS services.

People who have accomplished and maintained recovery can empower individuals seeking their own path to recovery. By sharing personal experiences, peers help build a sense of community and increase the quality of life of for members just beginning their recovery journey.

Peer and Recovery Support Specialists Qualifications & Certification

Individuals seeking to be certified and employed as Peer and Recovery Support Specialists (PRSS) must:

- Be at least 18 years of age
- Consent to their PRSS credentials being shared with Molina and AHCCCS registered providers for verifying compliance with AMPM 963, and

Self-identify as an individual who:

- Has their own lived experience of behavioral health conditions, for which they have sought support,
- Can attest to self-managing and maintaining their own recovery and/or wellness for a minimum of one year, and
- Has an experience of recovery to share, and
- Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals seeking certification and employment as a Peer and Recovery Support Specialists must complete and pass a competency exam with a minimum score of 80% upon completion of required training through AHCCCS-recognized Peer Support Employment Training Program. Certification through an approved Peer Support Employment Training Program is applicable statewide.

Individuals credentialed in another state must submit their credentials to AHCCCS/DCAIR, OIFA via email at oifa@azahcccs.gov.

Peer Support Employment Training Program Approval Process

A Peer Support Employment Training Program must submit their program curriculum, including a description of reasonable accommodations and alternative formats of program materials for the accessibility of program materials by all audiences, to AHCCCS/DCAIR Office of Individual and Family Affairs.

The OIFA Alliance, a collaborative of all OIFAs in Arizona, will review all PSETP applications for approval based on the required curriculum Core Elements outlined in AMPM 963. If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a service

provider or tribal community, the additional requirements shall not prevent recognition of a PRSS credential issued in compliance with AHCCCS requirements.

If a program makes substantial changes to its curriculum (e.g., changes to content) or if there is an addition to required elements, the program shall submit the updated content to OIFAAlliance@azahcccs.gov for review.

Peer Support Employment Training Curriculum Standards

A Peer Support Employment Training Program curriculum must include, at a minimum, the following core elements. More details can be found in AMPM Policy 963.

a. Concepts of Hope and Recovery:
b. Advocacy and Systems Perspective
c. Psychiatric Rehabilitation Skills and Service Delivery
d. Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace

Peer Support Employment Training Programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA).

Clinical Supervision and Continuing Education

Supervision is intended to provide support to Peer and Recovery Support Specialists in meeting the treatment needs of the members they are serving. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing Peer and Recovery Support Specialists must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the Peer and Recovery Support Specialist's qualifications as a Behavioral Health Technician, Behavioral Health Professional or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of Evidenced Based Practices in providing supervision to Peer and Recovery Support Specialists.

Agencies shall ensure that their staff employed as a PRSS have access to a minimum of eight hours of continuing education and ongoing learning, relevant to peer support, per year, with at least one hour covering ethics and boundaries relates to the practice of peer support.

Process for Submitting Evidence of Certification

Agencies employing Peer and Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and certification.

Molina Healthcare Plan will ensure through audits that Peer Support Specialists/Recovery Support Specialists meet qualifications and have a certification.

Partnership Requirements with Families and Family Run Organizations in the Children and Adult Behavioral Health System:

AHCCCS promotes various family roles and partnerships with families and family- run organizations within the children and adult behavioral health system. The involvement of families has made a significant contribution to improving the service system. Treatment decisions are also made through a collaborative approach with the member guiding the direction of their care.

Molina's providers must:

- Ensure that families have access to information and can have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are primary decision-makers in services planning and delivery.
- Provide culturally and linguistic relevant services that appropriately respond to a family's unique needs.
- Assess the family's need for a family support partner and make family support available when requested.
- Provide information to families on how they can contact staff at all levels of the service system.
- Work with Molina to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth, and young adults.

12. QUALITY

Maintaining Quality Processes and Programs

Molina collaborates with members and providers to maintain a comprehensive quality improvement program. You can contact the Molina quality department by phone

Quality of care concerns, seclusion and restraint reporting: MCCAZ- QOC@MolinaHealthcare.com

Provider audit questions: MCCAZ-Quality@MolinaHealthcare.com Performance improvement initiatives: MCCAZ-HEDIS@MolinaHealthcare.com

The address for mail requests is:

Molina Healthcare
Attn: Quality Department
5055 E Washington St, Suite 210
Phoenix, AZ 85034

This provider manual contains excerpts from the Molina quality improvement program. For a complete copy of Molina's quality improvement program, you can contact your provider services representative or call the telephone number above to receive a written copy.

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

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

- Have a quality improvement program in place
- Comply with and participate in Molina's quality improvement program, including reporting of access and availability survey, 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 access and availability
- Allow access to Molina quality personnel for site and medical record review processes

Access and Availability Standards

24-Hour Coverage

All providers must provide coverage 24 hours a day, 7 days a week. Regular hours of operation must be clearly defined and communicated to the members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider

call coverage or other customary means approved by Molina. The after-hours coverage must be accessible using the medical office's daytime telephone number, and the call must be returned within 30 minutes of initial contact.

Coverage During Absence

The provider must arrange for coverage of services during absences due to vacation, illness, or other situations that render the provider to be unable to provide services. A Molina participating provider must provide coverage.

Appointment Wait Time Requirement

The provider must offer appointments to our members in accordance with the state standards for timely access to care and services considering the urgency of the need for services and within the time frames outlined below.

Providers shall ensure that the provider's office staff is aware of and follows the standards as described in this provider manual. Molina monitors appointment availability standards of its providers on a routine basis to ensure that the provider's offices are compliant with these requirements as stipulated below and in accordance with AHCCCS ACOM Policy 417.

Additional information can be found online at: www.tst.azahcccs.gov/shared/Downloads/ACOM/ PolicyFiles/400/417_Appointment_A v ailability_Monitoring_and_Reporting.pdf

General appointment wait time standards:

- Emergency care services are available on the same day of the member request PCP appointments:
- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than two business days of the request
- Routine sick care (non-urgent) appointments are available within one week of the request

  Routine care appointments are available within twenty-one (21) calendar days of the request (This standard does not apply to appointments for routine physical examinations or for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.)

Specialty provider appointments:

- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than two business days of the request
- Routine care (non-urgent) appointments are available within forty-five (45) calendar days of the request

Dental provider appointments:

- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than three business days of the request
- Routine care (non-urgent) appointments are available within forty-five (45) calendar days of the request

Maternity care provider appointments:

- Initial prenatal care appointments for enrolled pregnant members shall be provided as follows:
  — First trimester- Within 14 calendar days of the request
  — Second trimester- Within seven calendar days of the request
  — Third trimester- Within three business days of the request
  — High-risk pregnancy- As expeditiously as the member's health condition requires, but no later than three business days of identification of high risk by Molina or by a maternity care provider, or immediately if an emergency occurs
- Emergency care services are available the same day of the member request

Behavioral health provider appointments:

- Urgent care appointments are available as expeditiously as the member's health condition requires, but no later than 24 hours of the request
- Routine care (non-urgent) appointments:
  — Initial assessment within seven calendar days of the referral or request for service
  — The first behavioral health service following the initial assessment: As expeditiously as the member's health condition requires, but no later than twenty-three (23) calendar days for members 18 years or older and twenty-one (21) calendar days for members under 18 years old after the initial assessment
  — All subsequent behavioral health services: As expeditiously as the member's health condition requires, but no later than forty-five (45) calendar days from identification of need

For psychotropic medications:

- Assess the urgency of the need immediately
- Provide an appointment, if clinically indicated, with a behavioral health medical professional within a time frame that ensures the member:
  (a) Does not run out of needed medications
  (b) Does not decline in his/her behavioral health condition prior to starting medication, but no later than thirty (30) calendar days from the identification of need

Timely Medical Evaluation

The provider will ensure that all patients have a professional evaluation within one hour of their scheduled appointment time. If a delay is unavoidable, the patient will be informed and provided an alternative.

Member Panel

A PCP panel may hold up to 1,500 members. Molina monitors PCP panel size regular to ensure that panels do not go over the 1,500 limit. If a PCP wishes to close their panel prior to reaching 1,500, the PCP should reach out to their provider relations representative.

PCP and specialty care providers understand the importance of maintaining open accessibility of Molina members to appropriate and covered health care services and agree to notify Molina immediately in the event that a PCP or specialty care provider is no longer able to accept new Medicaid members in the practice.

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 health practices for our members through our safety program, pharmaceutical management and care management/health 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) and the Department of 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 and Incident, Accident & Death Reporting

Under the leadership and directive of Molina's Chief Medical Officer, the Molina Healthcare Quality Management (Molina QM) unit has a systematic process to review and investigate any potential quality of care concerns that involves a Molina member. The QM unit monitors the quality of care and provision of services to members by individual and organizational providers within the service network.

Molina QM collaborates with providers to educate on Incident, Accident and Death (IAD) reporting requirements as defined in AMPM Policy 961 (AMPM Policy 961 (azahcccs.gov)). Molina Healthcare requires all providers to register for an account in the AHCCCS QM Portal within 30 days of becoming an AHCCCS registered provider.

In the event in which an occurrence causes harm, may cause harm, and/or death of a member, Molina Healthcare requires providers to submit an IAD through the AHCCCS QM Portal (Log In (azahcccs.gov)). This must be submitted within two business days of becoming aware of the occurrence, or in the case of a sentinel event, providers are required to submit an IAD through the AHCCCS QM Portal within one business day.

IAD is defined as follows:

1. Allegations of abuse, neglect, or exploitation of a member,
2. Death of a member,
3. Delays or difficulties in accessing care (e.g., outside of the timeline specified in ACOM Policy 417)
4. Healthcare acquired conditions and other provider preventable conditions (refer to AMPM Policy 960 and AMPM Policy 1020),
5. Serious injury,
6. Injury resulting from the use of a personal, physical, chemical, or mechanical restraint or seclusion (refer to AMPM Policy 962 (azahcccs.gov)
7. Medication error occurring at a licensed residential Provider site including:
   a. Behavioral Health Residential Facility (BHRF),
   b. DDD Group Home,
   c. DDD Adult Developmental Home,
   d. DDD Child Developmental,
   e. Assisted Living Facility (ALF),
   f. Skilled Nursing Facility (SNF),

g. Adult Behavioral Health Therapeutic Home (ABHTH), or

h. Therapeutic Foster Care Home (TFC), and any other alternative Home and Community Based Service (HCBS) setting as specified in AMPM Policy 1230-A and AMPM Policy 1240-B.

8. Missing person from a licensed Behavioral Health Inpatient Facility (BHIF), BHRF, DDD Group Home ALF, SNF, ABHTH, or TFC,

9. Member suicide attempt,

10. Suspected or alleged criminal activity, and

11. Any other incident that causes harm or has the potential to cause harm to a member. Incident, Accident, and Death (IAD) which involves a "sentinel event" as specified in AMPM Policy 961 AMPM Policy 961 (azahcccs.gov) must be submitted to Molina Healthcare within one business day of the occurrence through the AHCCCS QM Portal (Log In (azahcccs.gov)).

Sentinel IAD is defined as followed:

1. Member death or serious injury associated with a missing person,

2. Member suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting,

3. Member death or serious injury associated with a medication error,

4. Member death or serious injury associated with a fall while being cared for in a healthcare setting,

5. Any stage 3, stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting,

6. Member death or serious injury associated with the use of seclusion and/or restraints while being cared for in a healthcare setting (see AMPM Policy 962 (azahcccs.gov))

7. Sexual abuse/assault on a member during the provision of services regardless of the perpetrator,

8. Death or serious injury of a member resulting from a physical assault that occurs during the provision of services, and

9. Homicide committed by or allegedly committed by a member.

Should providers experience a delay in registering or accessing the AHCCCS QM Portal, providers are required to submit reportable and/or sentinel IADs to Molina QM via email at MCCAZ-QOC@MolinaHealthcare.com in accordance with AMPM Policy 961.

For further information and/or questions, please contact Molina Quality Management Unit at MCCAZ-QOC@molinahealthcare.com.

Seclusion and/or Restraint (SAR) Reporting

SAR Individual Event Reporting

Molina Healthcare individual and organizational contracted providers who are licensed to administer SARs are required to report all Molina Healthcare member events within five business days to Molina Healthcare Quality Management (Molina QM) at MCCAZ-QOC@MolinaHealthcare.com. When reporting an SAR event to Molina QM, the following SAR documentation must be included:

- AMPM Policy 962 - 962AttachmentA.docx
- SAR Initiating Orders
- SAR Flowsheets/Monitoring Logs

Please Note: Any SAR event that results in a death, injury and/or complication requiring medical attention must be reported to Molina via the AHCCCS QM Portal (https://qmportal.azahcccs.gov) as an IAD report within 24 hours of the incident.

AHCCCS requirements for SAR reporting to Molina QM can be found at AMPM Policy 962.

SAR Monthly Reporting

Molina QM reinstated monthly SAR reporting requirements to ensure that individual and organizational contracted providers who are licensed to administer SARs are following the reporting requirements of individual member SAR events in alignment with AMPM Policy 962.

The Molina QM *Seclusion and/or Restraint Monthly Reporting Form* shall be utilized by providers to list the individual Molina member SAR events that were reported to Molina Healthcare in the month prior or indicate no SAR events occurred. This allows Molina QM to confirm all individual member SAR events have been reported as outlined in AMPM Policy 962.

The *Seclusion and/or Restraint Monthly Reporting Form* can be found on the Molina Healthcare of Arizona website located here.

Providers are required to submit the Monthly Reporting Form by the 5th of the month to Molina QM at MCCAZ-QOC@MolinaHealthcare.com.

If it is determined that an individual SAR event was not previously reported, Molina QM will work with the provider to ensure that the individual SAR event is submitted.

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to members is consistently documented, and that necessary information is readily available in the medical record. All entries will be indelibly added to the member's record. PCPs should maintain the following medical record components that include, but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records
- Medical record content and documentation standards, including preventive health care
- Storage maintenance and disposal processes
- Process for archiving medical records and implementing improvement activities

Medical Record Keeping Practices

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

- Each patient has a separate record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available during each visit, and archived records are available within twenty-four (24) hours
- If in hard copy form, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the records dictates

- If in electronic form, all those with access have individual passwords
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity.
- Storage maintenance for the determined timeline and disposal per record management processes
- Process is in place 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, but not be limited to, the following information:

- The patient's name or ID number on each page in the record.
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact
- Legible signatures and credentials of the provider and other staff members within a paper chart.
- A list of all providers who participate in the member's care.
- Information about services that are delivered by these providers.
- A problem list that describes the member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within thirty (30) days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that an advance directive, power of attorney and living will have been discussed with the member; a copy of an advance directive when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months or as needed and included in the next preventive care visit when appropriate.
- Notes from consultants if applicable.
- Updated immunization records and documentation of appropriate history.
- All staff and provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.

- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history, physicals, and operative report.
- Labor and delivery record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped, or attached to the file
- Chart sections are easily recognized for the 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 the provider at each encounter
- The medical record is available to Molina for purposes of quality improvement
- The medical record is available to AHCCCS 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 no 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. Provider surveyed include OB/GYN (high-volume specialists), Oncologist (high impact specialists), and behavioral health providers. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90 percent availability for emergency services and 80 percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to members.

Women's Health Access

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

Additional information on access to care is available 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 member's 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 practice 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 ten 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.
- A system is in place to ensure expired sample medications are not dispensed; 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 not an 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 and older, 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 CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to download. Additionally, the Molina website offers information to both providers and members regarding advance directives, with a link to forms that can be downloaded and printed.

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

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

In no event may any provider refuse to treat a member or otherwise discriminate against a member because the member has completed an advance directive. CMS law gives members the right to file a complaint with Molina or the state survey and certification agency if the member is dissatisfied with

Molina's handling of advance directives and/or if a provider fails to comply with advance directive instructions.

Molina will notify the provider via fax of an individual member's advance directives identified through care management or care coordination. 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. Advance directives 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 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 and published in Periodicity schedules for medical providers (AMPM 430, Attachment A) and dental providers (AMPM 431, Attachment A). Molina's quality or the provider services department are 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.

Medical providers servicing EPSDT members are to use AHCCCS-approved EPSDT Clinical Sample Templates and standardized developmental screening tools. Clinical Sample Templates can be located on the Molina provider website: Provider Forms | Molina Healthcare of Arizona. For training needs on developmental screening tools, contact provider services.

HEDIS Measures

Pediatric Measures:

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
- Oral health screening and dental assessment and services
- Health education including anticipatory guidance such as child development, healthy lifestyles, accident, and disease prevention)

STI screening beginning at age 10 and testing for Syphilis at the age of 15o Discussing multiple open care gaps during the well child visit is considered best practice as it allows the member to not have

multiple unnecessary appointments but also allows providers to close multiple gaps on a single visit. If your practice provides dental services, this can be a same day/add on service to the well child visit. Ensure to utilize the appropriate codes to ensure dental gap closures.

Ways to Improve HEDIS® Scores:

- Schedule synchronous telehealth visits to complete well-care visits.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a well-care visit, immunizations, and BMI percentile calculations.
- Make sports/day care/camp physicals into well-care visits by performing the required services and submitting appropriate codes.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits

Measures that can be closed during a Well-Child Visit:

1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
   o The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN provider and who had evidence of the following during the measurement year:
     - BMI percentile documentation. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
     - Counseling for nutrition documentation or referral for nutrition education.
     - Counseling for physical activity documentation or referral for physical activity.
       o *Please note for measurement year 2026, the Weight Assessment and Counseling for Nutrition (WCC- Nutrition) has become an AHCCCS withhold measure.*

2. Childhood Immunization Status (CIS)
   The percentage of children 2 years of age who had the following vaccines by their second birthday:
   - At least four diphtheria, tetanus, and acellular pertussis (DTaP) vaccinations with different dates of service.
   - At least three polio (IPV) vaccinations with different dates of service.
   - At least one measles, mumps, and rubella (MMR) on or between the child's first and second birthdays, or all of the following any time on or before the child's second birthday
   - At least three hemophilus influenza type B (HiB) vaccinations with different dates of service.
   - At least three hepatitis B (HepB) vaccinations with different dates of service.
   - At least one chicken pox (VZV) vaccination with a date of service on or between the child's first and second birthdays. (Or history of chicken pox (VZV) on or before the child's second birthdays.)
   - At least four pneumococcal conjugate (PCV) vaccinations with a date of service on or between the child's first and second birthdays.
   - At least one hepatitis A (HepA) vaccination with a date of service on or between the child's first and second birthdays.
   - At least two doses of the two-dose rotavirus (RV) vaccinations on different dates of service.

- At least two influenza (flu) vaccinations with different dates of service on or before the child's second birthday

3. Immunizations for Adolescents (IMA)
   The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates:
   - Meningococcal: At least one meningococcal serogroups A, C, W, Y vaccine with a date of service on or between the member's 11th and 13th birthdays
   - Tdap: At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthdays
   - HPV: At least two HPV vaccines on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart
   - Combination 1 (Meningococcal, Tdap)
   - Combination 2 (Meningococcal, Tdap, HPV)

4. Lead Screening in Children (LSC)
   The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning on or before their second birthday.
   - Best practice would include a standing order for all members that fall within the LSC denominator.
     - *Please note that for measurement year 2026 this has become an AHCCCS withhold measure*

5. Developmental Screening in the First Three Years of Life (DEV-CH)
   The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

6. Topical Fluoride for Children
   The percentage of members 1–4 years of age who received at least two fluoride varnish applications, on different dates of service, during the measurement year.

7. Oral Evaluation, Dental Services (OED)
   The percentage of members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

8. Sealant Receipt on Permanent First Molars (SFM-CH)
   Percentage of enrolled children who have ever received sealants on permanent first molar teeth by the 10th birthdate: (1) at least one sealant and (2) all four molars sealed.

Well-Child Visits in the First 30 Months of Life (W30)

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: 1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. 2. Well-Child Visits for Age 15 Months-30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Ways to Improve HEDIS® Scores

- Schedule synchronous telehealth visits to complete well-care visits.
- Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a well-child visit, immunizations, and lead testing.
- Make day care physicals into well-care visits by performing the required services and submitting appropriate codes.
- Medical record details should include, but not limited to, growth charts, well-child visit forms, health history and physical, sports or school physical forms and vitals sheet.

Adult Measures:

Breast Cancer Screening

The percentage of members 40–74 years of age who were recommended for a routine breast cancer screening and had a mammogram to screen for breast cancer

- Please note: That as of 2025, the NCQA has adjusted the included population to ages 40-74
- Additional best practice is including a mammogram as a standing order for your patients, this allows the member flexibility to be seen at a imaging facility at any point in time during the year and ensure the screening is completed.

Ways to Improve HEDIS® Scores

- Educate members about the importance of early detection and encourage testing.
- Use needed services list to identify members in need of mammograms.
- Document a bilateral mastectomy in the medical record and fax Molina Healthcare the chart.
- Schedule a mammogram for member or send/give member a referral/script (if needed).
- Create a list of mammogram facilities to share with members.
- Discuss possible fears the member may have about mammograms and inform women that currently available testing methods are less uncomfortable and require less radiation
  - *Please note that, while a focus for Molina, this measure is not an AHCCCS withhold for measurement year 2026.*

Cervical Cancer Screening (CCS)

The percentage of members 21-64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members 21-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Members 30-64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30-64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting performed within the last 5 years

Ways to Improve HEDIS® Scores

- Request to have results of Pap tests sent to you if done at an OB/GYN visit.
- Document in the medical record if the member has had a total hysterectomy with no residual cervix and fax Molina the chart (please see codes above).

- Avoid missed opportunities (e.g., completing PAP tests during regularly scheduled well woman visits, sick visits, urine pregnancy tests, UTI and chlamydia/STI screenings).

Colorectal Cancer Screening (COL-E)

The percentage of members 45-75 years of age who had one of the following screenings for colorectal cancer:

- Fecal Occult Blood Test: gFOBT or iFOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- Stool DNA (sDNA) with FIT test during the measurement year or the two years prior to the measurement year.
- Additional best practice is including a colonoscopy of a FIT/FOBT kit as a standing order for your patients, this allows the member flexibility to be get their screening done at any point in time during the year and ensure the screening is completed.

Ways to Improve HEDIS® Scores

- Update member history annually regarding colorectal cancer screening with type and date of test completed.
- Encourage members who are resistant to having a colonoscopy to have a stool test that can be completed at home.
- Communicate to the member that iFOBT/FIT has fewer dietary restrictions and samples.
- Utilize standing orders and empower office staff to distribute FOBT or FIT kits to members who need colorectal cancer screening or prepare referral for colonoscopy.
- Document members with ileostomies, which implies colon removal (exclusion) and members with a history of colon cancer.
- When documenting a member reported colonoscopy, flexible sigmoidoscopy, FIT-DNA test, CT Colonography or FOBT, when available, always include a date of service, though, year of test will be acceptable for compliance.
  - *Please note that, while a focus for Molina, this measure is not an AHCCCS withhold for measurement year 2026.*

Asthma Medication Ratio (AMR)

The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Members are in the measure if they met at least one of the following during both the measurement year and the year prior:

- At least one ED visit or acute inpatient encounter with a principal diagnosis of asthma.
- At least one acute inpatient discharge with asthma as a principal diagnosis on the discharge claim.
- At least four outpatient visits, observation visits, telephone visits or e-visits or virtual check-ins, on different dates of service, with any diagnosis of asthma and at least two asthma medication

dispensing events for any controller or reliever medications. Visit type need not be the same for the four visits.

- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication dispensing events for any controller or reliever medication. Use all the medication lists in the table below to identify asthma controller and reliever medications.
  - o *Please note that, while a focus for Molina, this measure is not an AHCCCS withhold for measurement year 2026.*

Ways to Improve HEDIS® Scores

- Educate patients on the use of asthma rescue and controller medications.
- Prescribe a long-term controller medication and provide reminders to your patients to fill the medication.
- Inform patients that mail-order delivery is available to them.
- Writing Prescriptions:
- Consider writing the controller medication for a 90-day refill.
- Schedule a telehealth appointment to diagnose patients with asthma and prescribe a controller or reliever medication.
- Medication Adherence:
  - o Inform the members of Molina's 90-day fill policy for all HEDIS® approved AMR medications.
  - o Inform the member of mail order pharmacy services through CVS (800) 875-0867.
  - o Members can go into a CVS Pharmacy, located in Target stores, to start the mail-order process. If the member does not have a good home address, shipments can be mailed to the store.
  - o Encourage members to sign up for autofill on medications. Members can sign up for autofill by downloading the CVS App, visiting a CVS location, or calling the number listed above.
  - o Molina Member Services can help members with questions.
  - o Providers can send a new electronic prescription to CVS Caremark Mail Service Pharmacy or fax to (800) 378-0323. CVS will contact the members to obtain demographics.
  - o Members can create an account by calling CVS or going to www.cvs.com

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Ways to Improve HEDIS® Scores:

- Use culturally and linguistically appropriate language to educate members about the importance of adhering to their medication therapy and follow-up visits with their BH provider(s).
- Routinely arrange the next appointment when the member is in the office. If the member misses a scheduled appointment, office staff should contact the member to
- Assess why the appointment was missed or
- Reschedule the appointment and assess the possibility of a relapse.
- Educate members about the local community support resources and what to do in an event of a crisis.
- Outreach to members who were recently prescribed antipsychotics or who have refills past due to confirm they are taking their medications and/or address any barriers to taking their medications.

- Care should be coordinated between providers. Encourage communication between the behavioral health providers and PCP.

Prenatal and Postpartum Care (PPC) Postpartum Care[AA10]

1. Prenatal:

The percentage of deliveries of live births on or between October 8th of the year prior to the measurement year and October 7th of the measurement year that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the health plan, with an OB/GYN, other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note with the date when the prenatal care visit occurred and evidence of one of the following:

- Documentation indicating the member is pregnant or references to the pregnancy, for example:
- Documentation in a standardized prenatal flow sheet, or documentation of LMP, EDD or gestational age or positive pregnancy test result, or documentation of gravidity and parity, or documentation of complete obstetrical history, or documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as: o Screening test in the form of an obstetric panel (must include all the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or TORCH antibody panel alone, or rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or ultrasound of a pregnant uterus

Ways to Improve HEDIS® Scores

- Schedule pre-natal care visits starting in the first trimester or within 42 days of enrollment with the health plan.
- A telehealth appointment with a pregnancy-related diagnosis code during the first trimester or within 42 days of enrollment with the health plan meets compliance for this measure.
- Ask front office staff to prioritize new pregnant patients and ensure prompt appointments for any patient calling for a pregnancy visit to make sure the appointment is in the first trimester or within 42 days of enrollment with the health plan.
- Have a direct referral process to OB/GYN in place.
- Complete and submit Molina's pregnancy notification as soon as a pregnancy diagnosis is confirmed.
- Refer Molina patients to our Pregnancy program.

1. Post Partum:

The percentage of deliveries of live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year that had a postpartum visit with an OB/GYN practitioner or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit.
- An encounter for postpartum care.

- Cervical cytology.
- A bundled service where the organization can identify the date when postpartum care was rendered. Documentation in the medical record must include a note with the date when the postpartum visit occurred AND one of the following:
- Pelvic exam.
- Evaluation of weight, BP, breasts, and abdomen.
- Notation of postpartum care, including, but not limited to: "Postpartum Care", "PP check", "PP care", "6-week check", or a preprinted "Postpartum Care" form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder or preexisting mental health disorders.
- Glucose screening for women with gestational diabetes.
- Documentation of any of the following topics: infant care or breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity or attainment of healthy weight.

Ways to Improve HEDIS® Scores:

- Schedule your member for a postpartum visit within 7 to 84 days from delivery.
- A telehealth appointment with a postpartum visit or cervical cytology code within 7 to 84 days from delivery meets compliance for this measure.
- Use the postpartum calendar tool from Molina Healthcare to ensure the visit is within the correct time frames.

Follow-Up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for members six years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and who had mental health follow-up service. Visits must occur after the date of discharge. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the members received follow-up within 7 days after discharge.

Ways to Improve HEDIS® Scores

- Discharge planning begins upon admission. Begin to identify in-network mental health providers and secure appointments prior to discharge. The first seven days of post-discharge the patient is at greater risk for rehospitalization and, within the first three weeks post-discharge the risk of self-harm is high.
- Ensure that the follow-up appointment is made with a mental health provider before the member leaves the hospital and is scheduled within seven days of discharge.
- A follow-up visit completed on the same day a patient is discharged does not close the care gap. If a patient's clinical needs warrants being seen the same day as they are discharged, then to close the care gap the patient needs to be seen again within that 7-day window.
- Schedule a tele-health or telephone appointment within seven days of discharge with a mental health provider before the patient leaves the hospital. Contact Molina Case Management if assistance is needed to obtain a follow-up appointment.

- Review medications with patients (and/or parent/caregiver as appropriate) to ensure they understand the purpose and appropriate frequency and method of administration. Emphasize the importance of consistency and adherence to the medication regimen The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of NCQA. The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for internal quality improvement purposes. Updated 1/30/2025. Page 3 of 4
- Follow-up visits must be supported by a claim or encounter to count toward the measure.
- Talk with members about the importance of follow-up care with a behavioral health provider.

Plan All-Cause Readmissions (PCR)

Members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Note: For Medicaid, report only members 18–64 years of age. A lower rate indicates better performance for this measure (i.e., low rates mean that fewer members are being readmitted).

Ways to Improve HEDIS® Scores:

Work the four elements of the Transitions of Care (TRC) measure:

1) Medication Reconciliation Post Discharge
2) Notification of Inpatient Admission
3) Patient Engagement After Inpatient Discharge,
4) Receipt of Discharge Information.

- Keep in mind that PCR is an event-based measure that patients can be in multiple times for each admission/discharge.
- Ensure a follow-up appointment is made before the patient leaves the hospital and is scheduled within 7 days of discharge. Contact Molina Case Management if assistance is needed to obtain a follow-up appointment.
- Ensure your patient understands their local community support resources.
- Review medications with patients (and/or parent/caregiver as appropriate) to ensure they understand the purpose and appropriate frequency and method of administration.
- Ensure accurate dates are documented for hospital discharge, scheduled outpatient appointments, and kept appointments

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.

Transportation Services

Molina offers transportation services to its members at no-cost to assist with transportation needs

to-and-from appointments/screening appointments. If a member is interested in obtaining more information regarding transportation information, the member can contact provider services at (800) 424-5891 (TTY: 711).

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 that the provider submit a written CAP to Molina within thirty calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information, and any response made by the provider, are included in the provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network 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. CPGs are reviewed at least annually, and more frequently as needed when clinical evidence changes, and approved by the quality improvement committee.

Molina CPGs include but are not limited to 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
- Unsheltered members and other SDoH 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 online at MolinaHealthcare.com and the provider manual. Notification of the availability of the preventive health guidelines are published in the Molina provider newsletter.

Culturally and linguistically appropriate 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 **Culturally and Linguistically Appropriate Services** section of this provider manual.

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Behavioral health survey
- Provider satisfaction survey
- Effectiveness of quality improvement initiatives

Molina evaluates continuous performance according to, or in comparison with, objectives, measurable performance standards and benchmarks at the national, regional and/or at the local and/or 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. Reduced member cost sharing.

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

Healthcare Effectiveness Data and Information Set

Molina utilizes the NCQA Healthcare Effectiveness Date and Information Set (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 is also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is the tool used by Molina to summarize member satisfaction with the providers, health care and service they receive. CAHPS® examines specific measures, including getting needed care, getting care quickly, how well doctors communicate, coordination of care, customer service, rating of health care and getting needed prescription drugs. The CAHPS® survey is administered annually in the spring to randomly selected members by an NCQA-certified vendor.

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

Behavioral Health Satisfaction Assessment

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on member experience with health care providers and health plans, Molina conducts a provider satisfaction survey annually. The results from this survey are very important to Molina as this is one of the primary methods used to identify improvement areas pertaining to the Molina provider network. The survey results have helped establish improvement activities related 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).

13. COMPLIANCE

Fraud, Waste and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste and abuse prevention and detection, 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 (DRA)

The 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
- Administrative remedies for false claims and statements

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

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

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

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina will take steps to monitor Molina-contracted providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

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

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

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

What is AKS?

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

a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

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

Marketing Guidelines and Requirements

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

Under Molina's policies, marketing means any communication to a beneficiary who is not enrolled with Molina, that can 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 relate to the types and form of communications that health plans, Providers and others can have with members and prospective members. Examples of such communications include those related to enrolling members, Member outreach, and other types of communications.

Stark Statute- The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission or causing the submission of Claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes-Oxley Act of 2002- 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: 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: Health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding), causing unnecessary costs to the state and federal health care programs.

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

Examples of Fraud, Waste and Abuse by a Provider

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

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

Examples of Fraud, Waste and Abuse by a Member

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

- Benefit sharing with persons not entitled to the member's benefits.
- Conspiracy to defraud state and federal health care programs.

- Doctor shopping, which occurs when a member consults a number of providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a member obtains a prescription from a provider for a condition that they do not suffer from, and the member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina claims examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the claims examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

The claims payment system utilizes system edits and flags to validate those elements of claims that 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 of Fraud, Waste and Abuse Detection

Through the implementation of claim 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 prepayment 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, 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.

Providers 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 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 164.501). 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 SIU 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 SSIU 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 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. The AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. The AlertLine telephone and web-based reporting is available 24 hours a day, seven (7) days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call the 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 the AlertLine can be made from anywhere within the United States with telephone or internet access.

The 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 www.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
Attn: Compliance
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Remember to include the following information when reporting:

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

Suspected fraud and/or abuse may also be reported directly to the state. To report suspected recipient fraud to AHCCCS, contact:

Provider Fraud

- In Maricopa County: (602) 417-4045
- Outside of Maricopa County: (888) ITS-NOT-OK or (888) 487-6686

Member

- In Maricopa County: (602) 417-4193
- Outside of Maricopa County: (888) ITS-NOT-OK or (888) 487-6686

If providers have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS Office of Inspector General (OIG).

Email: AHCCCSFraud@azahcccs.gov
Website: www.azahcccs.gov/Fraud/ReportFraud/

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

HIPAA (The Health Insurance Portability and Accountability Act)
Molina's Commitment to Patient Privacy

Protecting the privacy of our members' personal health information is a core responsibility that Molina takes very seriously. Molina is committed to complying with all federal and state laws regarding the privacy and security of members' protected health information (PHI).

Provider Responsibilities

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

1. A covered entity may disclose PHI to another covered entity or a health care provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA privacy rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of services[2].
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI if each covered entity either has or has 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)

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

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

who are not the patients of the provider. In such cases, the provider shall return or securely destroy the PHI of the affected Molina members in order to protect their privacy. The provider agrees to not further use or disclose such PHI, and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

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

Patient Rights

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

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

2. **Requests for Restrictions on Uses and Disclosures of PHI**
Patients may request that a health care provider restrict its uses and disclosures of PHI. The provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**
Patients may request that a health care provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

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

5. **Request to Amend PHI**
Patients have a right to request that the provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**
Patients may request an accounting of disclosures of PHI made by the provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations.

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

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

1. Click on the area titled "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 NPI Rule promulgated under HIPAA. The provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the provider. The provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina within thirty (30) days of the change.

Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to Molina.

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

- UM
- 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

Information Security and Cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s), and in connection with such delegated functions.

1. Definitions:
   (a) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.
   (b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which 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, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.
   (c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.
   (d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.
   (e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited

to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp") NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:

i. Molina's proprietary and/or confidential information;
ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and
iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Molina Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

(a) Policies, Procedures, and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via written request, and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider.
ii. Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

iii. <u>Security</u>. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

iv. <u>Software Maintenance</u>. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) <u>Technical Standards</u>. Provider shall comply with the following requirements and technical standards related to network and data security:

i. <u>Network Security</u>. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. <u>Cloud Services Security</u>: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. <u>Data Storage</u>. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. <u>Data Encryption</u>. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. <u>Data Transmission</u>. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. <u>Data Re-Use</u>. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina .

3. <u>Business Continuity ("BC") and Disaster Recovery ("DR")</u>. Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt

Provider's delivery of services to Molina .

(a) <u>Resilience Questionnaire</u>. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b) <u>BC/DR Plan</u>.

    i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("<u>BC/DR Plan</u>"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:

        a) Notification, escalation and declaration procedures.

        b) Roles, responsibilities and contact lists.

        c) All Information Systems that support services provided to Molina.

        d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina.

        e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.

        f) Detailed list of resources to recover services to Molina including but not limited to: applications, systems, vital records, locations, personnel, vendors, and other dependencies.

        g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.

        h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

    ii. To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

    iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) <u>Notification</u>. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed twenty-four (24) hours, of either of the following:

    i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.

    ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) <u>BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).</u>

4. <u>Cybersecurity Events</u>.
   (a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.
   (b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than twenty-four (24) hours from Provider's discovery of the Cybersecurity Event.
      i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within twenty-four (24) hours following such payment.
      ii. Within fifteen (15) days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.
   (c) 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
       Molina Chief Information Security Officer
       Molina Healthcare, Inc.
       200 Oceangate Blvd., Suite 100
       Long Beach, CA 90802
   (d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina
   (e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina , complete an investigation pursuant to the following requirements:
      i. make a determination as to whether a Cybersecurity Event occurred;
      ii. assess the nature and scope of the Cybersecurity Event;
      iii. identify Molina 's Information that may have been involved in the Cybersecurity Event; and
      iv. 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 Molina Information.

(f) Provider must provide Molina the following required 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 must include at least the following, to the extent known:

    i. the date of the Cybersecurity Event;

    ii. a description of how the information was exposed, lost, stolen, or breached;

    iii. how the Cybersecurity Event was discovered;

    iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;

    v. the identity of the source of the Cybersecurity Event;

    vi. 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;

    vii. a description of the specific types of information accessed or 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;

    viii. the period during which the Information System was compromised by the Cybersecurity Event;

    ix. the number of total consumers in each State affected by the Cybersecurity Event;

    x. 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;

    xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;

    xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and

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

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

5. <u>Right to Conduct Assessments; Provider Warranty</u>. 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. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. <u>Other Provisions.</u> Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider but are not contained in this section.

7. <u>Conflicting Provisions</u>. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

Artificial intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by <Molina> from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

14. CLAIMS AND COMPENSATION

Payer ID	MCC01
Availity Essentials portal	**https://www.availity.com/molinahealthcare/**
Clean Claim Timely Filing	6 months – 180 days of the date of service.

Electronic Claim Submission

Molina strongly encourages participating providers to submit claims electronically, including secondary claims. Electronic claims submission provides significant benefits to the provider, including:

- Helping to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing claim delays since errors can be corrected and resubmitted electronically
- Eliminating mailing time which allows 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 via your regular EDI clearinghouse using Payer ID MCC01

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 (CMS-1450 [UB04]) claims with attached files including medical records and information.
- Correct/void claims.
- Add attachments, including medical records and information, to previously submitted claims.
- Check claims status.
- View electronic remittance advice (ERA) and explanation of payment (EOP).
- Create and manage claim templates.
- Create and submit a claim appeal with attached files.
- Manage overpayment invoices (Inquire, Dispute and Resolve) Clearinghouse

Molina uses The SSI Group as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, providers can continue to submit claims to their usual clearinghouse.

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

Molina accepts EDI transactions through our gateway clearinghouse for claims via the 837P for professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports 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.

Timely Claim Filing

Providers shall promptly submit to Molina claims for covered services rendered to members. All claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the provider to Molina within 180 calendar days after the discharge for inpatient services or the date of service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, providers must submit claims to Molina on the payment date on the primary insurance EOP or MSN after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to Molina within these timelines shall not be eligible for payment, and provider hereby waives any right to payment.

Claim Submission

Participating providers are required to submit claims to Molina with appropriate documentation. Providers must follow the appropriate state and CMS provider billing guidelines as well as any criteria explicitly required in the **AHCCCS Provider Manual, page 51:** https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html. Providers must utilize electronic billing though a clearinghouse or the Availity Essentials portal whenever possible, use current HIPAA compliant American National Standards Institute (ANSI) X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID MCC01. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim submission instructions on the Molina Member 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 thirty (30) calendar days from the change. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

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 - 7.

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)
- 10-digit National Provider Identifier (NPI) of the Billing Provider or Group
- Rendering provider information when different than billing
- Billing/pay-to provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- 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 Claim 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 resubmissions 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 - 7. 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.

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.

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.

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.

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 issue, the provider should contact their Provider relations representative for additional support.

Paper Claim Submissions

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

Molina Healthcare of AZ
PO Box 93152
Long Beach, CA 90809-9994

When submitting paper claims:

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

- Claims must be typed with either ten (10) or twelve (12) point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected Claim Process

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

Molina strongly encourages participating Providers to submit Corrected Claims. Corrections may be submitted electronically via EDI or, the Provider Portal Availity Essentials portal.

All Corrected Claims:

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

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

Corrected Claims must be sent within 12 months of the end 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)

Coordination of Benefits (COB) - Molina shall coordinate payment for covered services in accordance with the terms of a Member's benefit plan, applicable state and federal laws and applicable CMS guidance. If Molina is the secondary payer due to COB, Providers shall bill primary insurers for items and services they provide to a Member before they submit Claims for the same items or services to Molina for reimbursement. Molina will adjudicate the Claim based upon the primary explanation of benefits (EOB) submitted and pay for covered services up to the secondary liability based upon COB payment guidelines. 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.

Medicaid coverage for Molina Medicare Members

There are certain benefits that will not be covered by Molina Medicare programs but may be covered by **fee-for-service Medicaid**. In this case, the Provider should bill Medicaid with a copy of the Molina Medicare remittance advice and the associated state agency will process the Claim accordingly.

After exhausting all other primary coverage benefits, Providers may submit Claims to Molina Medicare. A copy of the remittance advice from the primary payer must accompany the Claim or the Claim will be denied. If the primary insurance paid more than Molina's contracted allowable rate the Claim is considered paid in full and zero dollars will be applied to Claim.

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

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

COB

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. If 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.

TPL

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 (HAC) and Present on Admission Program (POA)

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

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)   econdary diabetes with hyperosmolarity

7) Catheter-associated urinary tract infection (UTI)

8) Vascular catheter-associated infection

9) Surgical site infection following coronary artery bypass graft – (CABG)

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 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

For additional information on the Medicare HAC/POA program including billing requirements, please refer to the CMS website at: www.cms.hhs.gov/HospitalAcqCond/.

Molina Coding Policies and Payment Policies

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

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate claims. Molina requires coding of both diagnoses and procedures for all claims. The required coding schemes are the International

Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System

Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient claims. Inpatient hospital claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

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

- Manuals and Relative Value Unit (RVU) files published by CMS, including:
  - o 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.
  - o In the absence of state guidance, Medicare National Coverage Determinations (NCD).
  - o In the absence of state guidance, Medicare Local Coverage Determinations (LCD).
  - o CMS Physician Fee Schedule RVU indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than state and federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Telehealth Claims and Billing

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

All telehealth Claims for Molina members must be submitted to Molina with correct codes for the plan type.

For guidance, please refer to the resources located at https://www.azahcccs.gov/Resources/ Downloads/DFSMTraining/2019/TelehealthServicesBi llingGuidelinesFFSPresentation.pdf. For additional information please refer to Molina's Telemedicine, Telehealth Services and Virtual Visits policy at Provider Telehealth Resource Guide

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 of March 23, 2010. Molina Healthcare, Inc. 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 the 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 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 (1) 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 codebooks.

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.

POS Codes

POS codes 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 code 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 number 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.

The Provider acknowledges Molina's right to conduct pre- and post-payment billing audits. The Provider shall cooperate with Molina's SIU and audits of claims and payments by providing access at reasonable times to requested claims information, the provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right, and where unprohibited by regulation, to 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 extrapolated 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 SIU suspects that there's fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

Claims processing will be completed for contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within 30 days after receipt of clean claims.

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

Electronic Claim Payment

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

Participating providers are required to enroll for EFT and 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 online at MolinaHealthcare.com or by contacting our provider services department.

Overpayments and Incorrect Payments Refund Requests

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

If, as a result of 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.

A copy of the overpayment request letter and details are available in the Availity Provider Portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment, or check status. This is Molina's preferred method of communication.

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 pursue reclamation billing for identified overpayments if the primary insurer is a Commercial payer, in which Molina will seek reimbursement of funds directly from the primary payer. Providers will not receive an overpayment request letter in these scenarios pursuant to state guidelines for commercial recoveries. For members with Medicare COB Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the overpayment.

Claim Disputes/Reconsiderations/Appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the Appeals and Grievances section of this Provider Manual.

Remittance Advice

Remittance advice is provided for all claim payments. The remittance advice addresses paid and denied, but not pended claims. Molina accepts both electronic and paper claims. Provider rights for claims disputes are included in the remittance advice with instructions and timeframes for submission for any claims that denied.

    a. Molina produces a remittance advice related to Molina's payments and/or denials to providers and each include at a minimum:
        i. The reason(s) for denials and adjustments,
        ii. A detailed explanation/description of all denials, payments, and adjustments,
        iii. The amount billed,
        iv. The amount paid,
        v. Application of Coordination of Benefits (COB) and copays, and
        vi. Providers rights for claim disputes.
    b. Molina includes information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. All paper remittance advices describe this information in detail. Electronic remittance advices also direct providers to the link where this information is explained and include a supplemental file where this information is explained.
    c. The related remittance advice is sent with the payment unless the payment is made by Electronic Funds Transfer (EFT). Any remittance advice related to an EFT is sent to the provider, no later than the date of the EFT.

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. For additional information, please refer to the Compliance section of this provider manual.

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.

Contractors may submit encounter files as often as desired throughout the month and within 210 days from the end date of service in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – institutional, 837P – professional, and 837D – dental. Data must be submitted with claims level detail for all non-institutional services provided.

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

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

Molina has created 837P, 837I, and 837D companion guides with the specific submission requirements available to providers.

When encounters are filed electronically providers should receive two (2) types of responses:

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

Provider Claims Dispute

Providers who disagree with the payment, denial or recoupment of a claim may send a claim dispute to us at:

Molina Healthcare
Attention: Provider Claims Disputes
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Disputes may also be sent via the Provider Portal at provider.molinahealthcare.com.

Claim disputes must be filed in writing no later than 12 months from the date of service (or date of discharge), 12 months after the date of eligibility posting, or within 60 days after the payment, denial, or recoupment of a timely claim submission; whichever is later.

Unless the provider and Molina agree to a longer period, Molina must mail a notice of decision within 30 days from the date of dispute receipt (regardless of Molina entry).

Encounter Validation Studies

Molina and our providers are contractually required to participate in this process. These studies help AHCCCS to monitor and improve encounter data.

Medical Claims Review

Molina uses the prior authorization process to ensure claims and billing are correctly meeting medical need for services. Please refer to the Health Care Services section of this manual for additional information.

15. MEMBER GRIEVANCES AND APPEALS

Definitions

AHCCCS defines as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by AHCCCS to make an authorization decision, or failure to respect the member's rights, as provided for in 42 CFR § 438.400 et seq.

Member Grievance Process

Molina is required to have a system in place to respond to grievances and appeals received from members, and we are required to furnish information about the grievance and appeals processes to all network providers and subcontractors. Molina ensures that individuals making decisions regarding grievances or appeals:

- Are not involved in any previous level of review or decision making or a subordinate of the decision maker
- Have the appropriate clinical expertise to make the decision

If the member chooses to have a health care decision maker (HCDM, someone like a family member or the provider), file the request (appeal/Grievance/Fair Hearing) on the member's behalf, we will need written permission, also known as an authorization to disclose. If we do not have written permission, we will send a letter to the member with a form for the member to sign to allow someone else to represent them. Molina will make three (3) attempts within seven (7) days at various times to speak to the member about getting the signed form. The case will be left open for limited time while we wait for the signed form to be returned.

For questions regarding member grievances and appeals, please contact Molina at (800) 424-5891 (TTY: 711). Molina will maintain a system that meets, at a minimum, the following standards:

- Timely acknowledgement of receipt of each member grievance;
- Timely review of each member grievance – as expeditiously as the member's condition requires;
- Standard response, electronically, or in writing, to each member grievance within a reasonable time, but no later than 10 business days after Molina receives the grievance, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed. 42 CFR 438.408(a), 42 CFR 438.408(b)(1).

If a member or their authorized designee (provider, family member, etc.) needs help with filing a grievance, please call us at department tollfree at (800) 424-5891. Interpreter services are available. Our Member Services department is available from Monday-Friday 8 a.m. to 6 p.m. MST. Members may also submit a grievance via the Molina Member Portal at member.molinahealthcare.com or via mail to:

Molina Healthcare
Attn: Grievance and Appeals Department
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Grievance Timelines

According to AHCCCS guidelines, Molina must resolve each grievance within ten

(10) business days after Molina receives the grievance, absent extraordinary circumstances; no grievances shall exceed 90 days for resolution date.

Appeals

An appeal is the request for review of an adverse benefit determination 42 CFR 438.400(b). Adverse benefit determinations are any of the following:

- 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
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as defined by the state;
- Failure to act within the time frames provided in 42 CFR 438.408(b)(1) and (2) required for standard resolution of appeals and standard disposition of grievances; or
- Denial of a rural member's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area
- Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities.
- Upon receipt of the adverse benefit determination the provider will have 10 days to request a peer to peer review during the appeal process not to exceed 15 days.

Appeals Process

If you disagree with our decision, you can file an appeal asking us to take a second look. We will not treat you or your provider unfairly because you file an appeal. Molina supports the right of our members to request a review of adverse actions or benefit determinations ("adverse determination"). Molina accepts requests from our members, their authorized representatives and their providers for any covered service that has been denied, reduced, suspended, or terminated. A member's authorized representative may be anyone who is authorized to file the appeals request on behalf of the member, so long as the member has provided written permission. Examples of designees include a family member, legal guardian, provider, or attorney.

Expedited Appeals Process and Timeline

If you disagree with our decision, you can file an appeal asking us to take a second look. We will not treat you or your provider unfairly because you file an appeal. Molina has an expedited review process for appeals if we or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. If a provider is filing an expedited appeal on behalf of a Molina member, a valid AOR/AUD/member's permission is required to file the appeal. We will resolve all expedited

appeals as expeditiously as the member's health condition requires, but no later than 72 hours from the date the Contractor receives the expedited appeal.

Members may file an expedited appeal with Molina within 60 calendar days from the date on the notice of adverse benefit determination. Appeals may be filed verbally, in writing, or via fax.

Standard Appeals Process and Timeline

Members may file a standard appeal with Molina within 60 calendar days from the date on the notice of adverse benefit determination. Appeals may be filed verbally, in writing, or via fax.

To file an appeal, members may call us at (800) 424-5891 (TTY: 711), Monday-Friday 8 a.m. to 6 p.m., MST. Our agents can provide assistance in completing the appeal request. Interpreter services are available, as needed. Members may also send us their written appeal via:

Molina Member Portal: member.molinahealthcare.com

Fax: (888) 656-7505

Mail:

Molina Healthcare
Attn: Grievance and Appeals Department
5055 E Washington St, Suite 210
Phoenix, AZ 85034

Molina will make a decision on an appeal within 30 calendar days from the initial date of receipt of the appeal. The written notification will include the decision and the reason for denial, including information on their second level appeal rights through the State Fair Hearing process with AHCCCS. This time may be extended by 14 calendar days if requested by the member or in the event Molina determines an extension is in the member's best interest.

Continuation of Benefits

While the appeal decision is being made, the member can continue to receive care for previously authorized services if the member requests a continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the member's favor, the member may be liable for the cost of the services if the services are upheld by Molina. If the final decision is in the member's favor, services will be reinstated within 72 hours for expedited and standard appeals.

State Fair Hearing Process

Members, their authorized representatives, or their provider have a right to appeal Molina's adverse determination on their appeal request through the State Fair Hearing process. Completion of Molina's appeal process is a prerequisite to filing for a State Fair Hearing. A member may also file for a State Fair Hearing if Molina fails to adhere to the required time frames for processing the member's appeal.

The appeal for a State Fair Hearing must be filed in writing within 90 days after receipt of Molina's appeal decision. Members needing assistance filing a State Fair Hearing may contact Molina at (800) 424-5891 (TTY: 711), Monday-Friday, 8 a.m. to 6 p.m. MST. Molina will attend and defend our

appeals decisions at all hearings or conferences in person or by phone as deemed necessary by AHCCCS.

If AHCCCS reverses a decision to deny, limit, or delay services, Molina must authorize the disputed services no later than 72 hours from the date Molina receives the notice reversing the decision. Molina does not have the right to appeal AHCCCS' appeal decisions.

Continuation of Benefits

While the State Fair Hearing decision is being made, the member can continue to receive care for previously authorized services if the member requests continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the member's favor, they may be liable for the services provided. If the final decision is in the member's favor, services will be reinstated within 72 hours.

Reporting

All grievance and appeal data, including provider-specific data, is reported quarterly to the member/provider satisfaction committee (MPSC) by the department managers for review and recommendation. A summary of the results is reported to the executive Quality Improvement and Health Equity Transformation Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the MPSC and EQIC by the chairman of MPSC; to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and grievances will be reported to the state on a monthly basis. Grievance and appeals reports will be reviewed monthly by the credentialing coordinator for inclusion in the trending of ongoing sanctions, complaints, and quality issues.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically via call tracking in QNXT or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the provider pertaining to the grievance and appeal process. Providers shall maintain records for a period not less than 10 years from the termination of the model contract and retained further if the records are under review or audit until the review or audit is complete. (Providers shall request and obtain government contracts prior approval for the disposition of records if the agreement is continuous.)

16. 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 per Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM) Policy 950. It is the objective of Molina to provide superior health care to the community. Additional information 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 under AMPM Policy 950 which includes Adverse Actions, updated Consumer Assessment of Healthcare Providers and Systems (CAHPS) information and completed applications. 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.

Credentialing Turnaround Time

Molina completes initial credentialing of Practitioners within 60 calendar days. The 60 calendar days is measured from the date Molina receives a full and complete credentialing application.

Type 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 psychologists with a master's degree
- Licensed/certified midwives (non-nurse)

- Massage therapists
- Clinical social workers with a master's degree
- Clinical nurse specialists or psychiatric nurse practitioners with master's degrees
- Medical doctors (MD)
- Naturopathic physicians
- Nurse midwives
- Nurse practitioners, including Certified Registered Nurse Anesthetists (CRNAs)
- Occupational therapists
- Optometrists
- Oral surgeons
- Osteopathic physicians (DO)
- Pharmacists
- Physical therapists
- Physician assistants
- Podiatrists
- Psychiatrists
- 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. 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's 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**- Practitioner 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'll 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.

- **Drug Enforcement Administration (DEA) Certificate –** Practitioners must hold a current, valid, DEA certificate. Practitioners must have a DEA certificate in every State where the Practitioner provides care to Molina members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate, or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) Certificate –** Practitioners must hold a current, valid AZ CDS certificate. Practitioners working from NM, NV or UT practice locations must meet CDS requirements in those states.
- **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're 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:
  o American Board of Medical Specialties (ABMS)
     American Osteopathic Association (AOA)
  o American Board of Foot and Ankle Surgery (ABFAS)
     American Board of Podiatric Medicine (ABPM)
  o American Board of Oral and Maxillofacial Surgery
     American Board of Addiction Medicine (ABAM)
  o College of Family Physicians of Canada (CFPC)
     Royal College of Physicians and Surgeons of Canada (RCPSC)
  o 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 a training program from an accredited training program are only eligible to be considered for

participation as a general practitioner in the Molina network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five 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 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 and physician assistants-** In certain circumstances, Molina may credential a practitioner who is not licensed to practice independently. In these instances, it would also be required that the practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work history-** 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-** Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional liability insurance-** Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **State sanctions, restrictions on licensure or limitations on scope of practice-** Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include statement of charges, notice of proposed disciplinary action or the equivalent.
- **Medicare, Medicaid and other sanctions and exclusions-** Practitioner must not be currently sanctioned, excluded, expelled, or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared

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[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

ineligible from receiving federal contracts, certain subcontracts and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

- **Medicare opt out-** Practitioners currently listed on the Medicare opt-out report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration death master file-** Practitioners must provide their social security number. That social security number should not be listed on the Social Security Administration death master file.
- **Medicare preclusion list-** Practitioners currently listed on the preclusion list may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional liability insurance-** Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina members and the practitioner's activities on Molina's behalf. Practitioners maintaining coverage under a federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to perform-** Practitioner must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **Lack of present illegal drug use-** Practitioner 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:
  - o Criminal convictions, including any convictions, guilty pleas, and or adjudicated pretrial diversions for crimes against a person such as murder, rape, assault, and other similar crimes.
  - o Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
  - o 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.
  - o Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
  - o Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.

- **Loss or limitations of clinical privileges-** At initial credentialing, practitioner 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, practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.
- **Hospital privileges-** Practitioners must list all current hospital privileges on their credentialing application. If the practitioner has current privileges, they must be in good standing.
- **NPI-**Practitioners must have an NPI issued by 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 not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner rights are published on the Molina website and are included in this provider manual.

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

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

Molina Healthcare, Inc.
Attention: Credentialing Director
22522 – 29th Drive SE, #L-210
PO Box 4004
Bothell, WA 98041

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

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

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner 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 allowing up to seven calendar days to coordinate schedules. A medical director and a director responsible for credentialing, or the quality improvement director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the practitioner are documents, which the practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner 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

Molina will approve or deny provider within 60 days of receipt of a completed application. Credentialing decisions are sent by the Medical Director within ten (10) days of the decision to the provider. A copy of the communication is filed in the provider's credentialing file within ten (10) days of the decision.

Professional Review Committee (PRC):

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to assure that network practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC.)

Molina utilizes information such as, but not limited to credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken.

Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined in Molina's policy. Please contact your provider representative for additional information about fair hearings.

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 practitioner when occurrences of poor quality are identified. If a Molina practitioner is found to be sanctioned or excluded, the practitioner 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 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 with 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

Effective 07/01/2025, Molina will monitor the timely renewal of healthcare licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, Molina may take action up to and including payment suspension for dates of service on or after license expiration or termination from applicable Molina provider networks.

Provider Appeal Rights

In cases where the credentialing committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

17. 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
6. Monitoring

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the provider/accountable care organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's delegation oversight committee (DOC), or other designated committee, must approve all delegation and sub- delegation arrangements. To remain a delegate, the provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

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

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina contract manager.

18. COVERED PHARMACY SERVICES

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our members with high-quality, cost- effective drug therapy. Molina collaborates with its 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 (OTC) drugs.

Pharmacy Policy

Prescription drug benefits are managed though Molina and are administered by a pharmacy benefit manager, CVS/Caremark. Molina offers coverage for outpatient prescription drugs listed on their preferred drug list (PDL). Medications not listed on the PDL will require prior authorization in order to be considered for approval.

Molina pharmacy claims are processed by CVS/Caremark. Molina members should obtain covered drugs from a pharmacy within the CVS/Caremark pharmacy network unless there is an emergency situation. The CVS/Caremark pharmacy network includes retail chain pharmacies, several local independent pharmacies and home infusion, mail order and specialty pharmacies. Additional information about the pharmacy network can be obtained by contacting Molina at (800) 424-5891 (TTY: 711).

Preferred Drugs

Molina uses a PDL. This is a list of prescription drugs approved by Molina for the use of our members and includes the approved AHCCCS PDL. Generic drugs, certain brand name drugs and certain specialty drugs listed in the PDL are covered. Some drugs, even though they are listed on the PDL, may have special limitations, such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non-PDL drugs may be requested through the service authorization process (see below). Some drugs are excluded from the pharmacy benefits, such as those for weight loss, infertility, and cosmetic purposes. The PDL is available to providers on the Molina website at MolinaHealthcare.com.

Providers can request a hardcopy of the PDL, by contacting Molina at 800-424-5891.

The Molina formulary is one single tier. If a drug is on the list, it is considered Tier 1, which means it is a covered drug.

The PDL does not:

1. Require or prohibit the prescribing or dispensing of any medication;
2. Substitute for the independent professional judgment of the physician or pharmacist; or
3. Relieve the physician or pharmacist of any obligation to the patient or others.

Medication additions or deletions to the PDL reflect the decisions made by the Molina Healthcare pharmacy therapeutics (P&T) committee, and those decisions are inclusive of the AHCCCS PDL.

The composition of the committee includes licensed pharmacists and medical doctors. Network providers have the right to submit formulary change requests to Molina by mail to:

Molina Healthcare
Attn to: Molina Pharmacy Director
5055 E Washington St, Suite 210
Phoenix, AZ 85034

The request must contain your clearly stated recommendation, reason for your recommendation and your contact information.

AHCCCS usually makes changes to the AHCCCS PDL quarterly. Those changes are also made to the Molina PDL quarterly. If a covered drug is removed from the PDL, Molina will send a written notification to the affected members at least 30 days before the change occurs. Providers are made aware of changes through provider bulletins that are emailed, faxed, or posted to the provider portal.

Pharmacy Prior Authorizations

The PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered by the Molina pharmacy program. If a patient requires medication that does not appear on the PDL, the physician can make a request for a non-preferred medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. In order for a member to receive coverage for a medication requiring prior authorization, the provider must initiate a service authorization request and indicate the reason for the exception. A service authorization request is the CVS/Caremark terminology for pharmacy prior authorization request. All relevant clinical information and previous drug history should be included. The request can be faxed or telephoned to:

Molina Healthcare c/o
CVS/Caremark

Fax: (844) 271-6887
Phone: (800) 424-5891 (TTY: 711)

You can find service authorization request forms online at MolinaHealthcare.com.

Denial of Pharmacy Services

If Molina denies a request for a service authorization, Molina will notify the provider via phone or fax within 24 hours of receipt of the request and issue a notice of action to the prescriber and the member. The notice of action will include appeal rights and instructions for submitting an appeal.

OTC Items

Certain OTC items are covered for our members. The Molina PDL covers several OTC medications and can be obtained at a pharmacy with a prescription from a provider.

Emergency Supply Policy

All participating pharmacies are authorized to call the CVS/Caremark Pharmacy Helpdesk to request

an override for a four-day supply of medication for an emergent situation. An emergent situation is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b)serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

The following drug categories are not part of the Molina PDL and are excluded by AHCCCS; therefore, they **are not covered by the emergency supply policy**:

1. Drugs used for anorexia or weight gain;
2. Drugs used to promote fertility;
3. Agents used for cosmetic purposes or hair growth;
4. Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
5. DESI (Drug Efficacy Study Implementation) drugs considered by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
6. Drugs that have been recalled;
7. Experimental drugs or non-FDA-approved drugs; and
8. Drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.

Newly Approved Products

Newly approved drug products won' normally be placed on the PDL during their first six months on the market. During this period, access to these medications will be considered through the PA review process.

Pharmacy and Therapeutics Committee

The Arizona Health Care Cost Containment System (AHCCCS) Pharmacy & Therapeutics Committee (Committee) is advisory to the AHCCCS Administration and is responsible for evaluating scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs. The Committee makes recommendations to the AHCCCS Administration on the development and maintenance of a statewide drug list and prior authorization criteria as appropriate. The Committee may also evaluate individual drugs and therapeutic classes of drugs.Federal regulations [42 C.F.R. § 456.703 - 456.725] require that Medicaid pharmacy programs establish and maintain a Drug Utilization Review (DUR) program that helps to ensure appropriate drug utilization by conducting prospective and retrospective drug utilization review and maintaining an educational program. The Molina Drug Utilization Review (DUR) board is organized to enhance and compliment activities mandated to state Medicaid programs and act as an advisory board to Molina National P&T for all drug utilization program activities. Drug utilization review program activities help to ensure that prescriptions for outpatient drugs are appropriate, medically necessary, and not likely to result in adverse medical consequences. DUR activities use professional medical protocols and computer technology and data processing to assist in the management of data regarding the prescribing of medicines and the dispensing of prescriptions over periods of time.

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 are available online at MolinaHealthcare.com or by calling Molina at (800) 424-5891.

Drug Formulary

The pharmacy program does not cover all medications. Molina keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescriptions (and over-the-counter products where applicable) that members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. Some medications require a 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 provider manual and is also available online at MolinaHealthcare.com.

Formulary Medications

Formulary medications with PA requirements may require the use of first-line medications before they are approved.

Information on procedures to obtain these medications is described within this document and is also available on the Molina website at MolinaHealthcare.com.

Quantity Limitations

In some cases, members may only be able to receive certain quantities of medication. Information on specific limits can be found in the formulary document. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. 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, which is available on the Molina website at MolinaHealthcare.com. 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. If the use of a particular brand name non-preferred drug becomes medically necessary as determined by the provider, PA must be obtained through the standard PA process.

New to Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit. Specific exclusions can be found in the formulary at MolinaHealthcare.com.

Submitting a Prior Authorization Request

Molina's vendor, CVS Caremark 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 and fax number
- Drug name, strength, quantity, and directions of use
- Diagnosis

Electronic prior authorization (ePA): SureScripts® and CoverMyMeds

CVS Caremark'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, CVS Caremark will either respond via the electronic prior authorization (ePA) portal, 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 form in its entirety, including medical justification and/or supporting clinical notes.

CVS Caremark utilizes PA portal submissions through the SureScripts® and CoverMyMeds® platforms that are integrated into physician office electronic health record (EHR) systems. The portal automates the prior authorization process, making it a quick and simple way to complete prior authorization requests. The ePA portal process is HIPAA compliant and can enable faster coverage determinations. For select drugs and plans, CoverMyMeds® may issue immediate approval of your

request and update your patient's prior authorization record to allow immediate claim adjudication. Fax a completed Medication Prior Authorization Request form to CVS Caremark at 844-271-6887 MolinaHealthcare.com or by calling Molina Call Center at (800-424-5891 EXT 756631 for AZ).

To research codes requiring prior authorization or download a prior authorization request form, visit the provider pages of our website at Molina Healthcare Prior Authorization and Pre-service Review Guide. Molina Healthcare requires prior authorization for planned facility admissions, select outpatient services including select procedures, medications, and dental services. All out-of-network providers require prior authorization for all services provided with the exception of most family planning services and supplies. Prior authorization is not required for emergency services.

To request or check the status of a prior authorization, use our provider portal at Log In to Availity® or complete a prior authorization request form and fax to the appropriate fax number listed below. Remember to include all supporting documentation such as clinical notes, labs, any additional diagnostic testing, history of failed treatments.

Fax a completed Molina prescription drug prior authorization drug form to Molina at by service type:

Outpatient Medicaid	888-656-7501	Dental (non-hospital)	262-241-7150
Inpatient Medicaid	888-656-2201	Dental (hospital and SPU)	262-834-3575
Advanced Imaging	877-731-7218	Transplant	877-813-1206
Pharmacy	844-271-6887		

A blank, fillable and printable Molina prescription drug prior authorization drug form may be obtained online at MolinaHealthcare.com or by calling (800) 424-5891 (TTY: 711).

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.

During the utilization management review process, Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify member eligibility, any federal or state regulatory requirements and the member-specific benefit plan coverage prior to determination of benefit processing.

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

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

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

Pain Safety Initiative (PSI) Resources

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

Molina is dedicated to ensuring providers are equipped with additional resources, which can be found on the Molina website. Providers may access additional opioid safety and substance use disorder resources online 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.

Drug Utilization Review

Molina Healthcare will conduct a prospective drug utilization review process for the following:

A. All drugs prior to dispensing:

1. Molina Healthcare will utilize a computerized DUR system to complete a review of all drugs prior to dispensing. At minimum, the DUR system will identify potential adverse drug reactions, drug-pregnancy conflicts, therapeutic duplications, and drug-age conflicts.

B. All non-formulary drug requests

1. Molina Healthcare will utilize a clinical pharmacist, who is licensed in Arizona, to review all non-formulary drug requests and to determine drug utilization safety and coverage.

2. Molina Healthcare will conduct a concurrent DUR for the following:

    a. For all drugs being dispensed during course of a member's treatment

        1. Molina Healthcare will utilize a computerized DUR system to identify issues similar to those identified by the prospective DUR. Additional clinical triggers include under/overutilization, drug-drug-interactions, low or high dosages, etc.

        2. Molina Healthcare's Medical Management Committee meets on a quarterly basis and conducts retrospective drug reviews to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse.

3. Pattern analyses will include the evaluation of clinical appropriateness, over- and underutilization, therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect duration of medication treatment, clinical abuse or misuse of medications, use of generic products and mail order medications.

4. Tracking and monitoring will be implemented specific to members utilizing controlled substances, including Schedule II medications as well as behavioral health medications. See Molina Healthcare Rx –Monitoring Prescription Use and Prescriber Trending Policy.

5. The Medical Management Committee will provide medication management education to providers and other healthcare professionals, within Molina Healthcare's provider network, with the aim of improving safety, prescribing practices, and therapeutic outcomes, which are based on the retrospective drug utilization review findings.

6. Molina Healthcare has the following processes implemented in accordance with CMS DUR requirements:

   A. Opioid safety edits at the Point-of-Sale,

   B. Member utilization when the cumulative current utilization of opioid(s) is a Morphine Equivalent Daily Dose (MEDD) of greater than ninety (90),

   C. Members with concurrent use of an opioid(s) in conjunction with benzodiazepine(s) and/or antipsychotic(s),

   D. Antipsychotic prescribing for children, and

   E. Fraud, waste, and abuse by enrolled members, pharmacies, and prescribing clinicians

7. Molina Healthcare tracks and monitors members eighteen years of age and younger that are prescribed antipsychotic medications and will refer to case management any member prescribed four or more antipsychotics.

Prescription Monitoring and Pharmacy or Prescriber Lock in Program

Molina monitors controlled and non-controlled medications on an ongoing basis at least quarterly throughout the year. Monitoring includes the evaluation of prescription utilization by members, prescribing patterns by clinicians and dispensing by pharmacies. Drug utilization data is used to identify and screen high-risk members and providers who may facilitate drug diversion or present quality of care concerns.

a) Molina Healthcare monitors, at a minimum on a quarterly basis, several therapeutic classes to determine potential misuse of these medications. The therapeutic classes in which Molina Healthcare monitors include:
   i. Atypical Antipsychotics,
   ii. Benzodiazepines,
   iii. Hypnotics,
   iv. Muscle Relaxants,
   v. Opioids, and
   vi. Stimulants

b) Molina Healthcare utilizes the following resources, when available, for their monitoring activities:
   i. Prescription claims data
   ii. Arizona State Board of Pharmacy CSPMP
   iii. Indian Health Service (IHS) and Tribal 638 pharmacy data
   iv. RBHA/TRBHA prescription claims data
   v. Provider trending reports
   vi. Other pertinent data

c) Molina Healthcare evaluates pertinent reporting to identify:
   i.   Number of prescribing physicians
   ii. Number of different pharmacies utilized by the member
   iii. Medication fill dates
   iv. Other potential indicators of medication misuse

d) All identified cases of member deaths, due to medication overdose, are referred to Molina Healthcare Quality Management for research and review.

e) When the reviewing pharmacist discovers any suspected fraud, waste, and abuse, the discovery is reported to Molina Healthcare Compliance Department as well as other appropriate entities (i.e., Office of Inspector General).

Molina assigns members who meet certain evaluation parameters to an exclusive pharmacy and/or single prescriber for a minimum 12-month period. Criteria for pharmacy and/or prescriber member assignment include any of the following:

1. Overutilization:
   a. Member utilized the following in a three-month time period:
      o ≥ four prescribers; and
      o ≥ four different abuse potential drugs; and
      o ≥ four Pharmacies, **or**
   b. Member has received twelve (12) or more prescriptions of the medications listed in section A-1 AHCCCS AMPM 310-FF in the past three months
2. Fraud- Member has presented a forged or altered prescription to the pharmacy
3. Referral from the Molina medical management clinical staff

In addition to exclusive pharmacy and/or prescriber restrictions, other interventions may include:
1. Member-specific point of sale safety edits and quantity limits as specified by the treating provider
2. Referral to a care manager for long-term follow-up care
3. Referral to a behavioral health service provider or other appropriate specialist

Molina members with one or more of the following conditions will not be subject to pharmacy and/or prescriber assignment or restriction:
1. Members with an active oncology diagnosis
2. Members receiving hospice care
3. Members residing in a skilled nursing facility

Members who are assigned to an exclusive pharmacy and/or an exclusive prescriber for 12 months are provided a written notice of action at least 30 days prior to the effective date of the assignment.

Restrictions are not implemented before providing members notice and opportunity for a hearing. If the member files a request for hearing, no restriction is imposed until such time that a resolution has been made.

Five Day Opioid Limit

Molina enforces the opioid days' supply limitation as required by AHCCCS.

Members under 18 years of age

A prescriber shall limit the initial and refill prescriptions for any short-acting opioid medication for a member under 18 years of age to no more than a five-day supply. An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member's pharmacy benefit manager (PBM) prescription profile.

The initial and refill prescription five-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Children on opioid wean at time of hospital discharge
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures
- Chronic conditions for which the provider has received PA approval through Molina

The initial prescription five-day supply limitation for short-acting opioid medications does not apply to prescriptions for post-surgical procedures. However, initial prescriptions for short-acting opioid medications for postsurgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post- surgical procedures are limited to no more than a five-day supply.

Members 18 years of age and older

A prescriber shall limit the initial prescription for any short-acting opioid medication for a member 18 years of age and older to no more than a five-day supply. An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member's PBM prescription profile.

The initial prescription five-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Skilled nursing facility care

- Traumatic injury, excluding post-surgical procedures
- Post-surgical procedures

Initial prescriptions for short-acting opioid medications for post-surgical procedures are limited to a supply of no more than 14 days.

Controlled Substances and E-Prescribing

From AHCCCS:

This information is to provide notification of the state of Arizona House Bill 2075 as it pertains to Electronic Prescribing of Controlled Substances and the links for additional information on available resources.

Beginning January 1, 2020, a Schedule II controlled substance that is an Opioid shall be dispensed only with an electronic prescription order as required by Federal Law or Regulation. The Arizona State Board of Pharmacy will not issue waivers to providers for this regulation.

This is a statutory mandate to all providers sending and pharmacies receiving Schedule II Opioid Prescriptions. Exceptions to HB2075 include federal facilities, for example, the Indian Health Service, the Department of Veterans Affairs, and the Department of Defense; these facilities are not subject to this regulation.

For additional information regarding HB2075, please click the link below to the Arizona State Board of Pharmacy website to view the Frequently Asked Questions tab "E- Prescribing of Schedule II Opioids Mandate." www.pharmacy.az.gov/faq.

Please contact the AHCCCS pharmacy department at AHCCCSPharmacyDept@azahcccs.gov with any questions.

General and Informed Consent

Informed consent is required to be obtained from a member or legal guardian prior to the provision of the following services and procedures as outlined in AMPM 320-Q:

1. Complementary and Alternative Medicine (CAM),
2. Psychotropic medications,
3. Electro-Convulsive Therapy (ECT),
4. Use of telemedicine,
5. Application for a voluntary evaluation,
6. Research,
7. Admission for medical detoxification, an inpatient facility, or a residential program (for members determined to have a Serious Mental Illness), and
8. Procedures or services with known substantial risks or side effects

Any member who is 18 years or older will need to give voluntary general consent to treatment for any of the above-mentioned procedures. The provider will need to demonstrate consent within the medical record via a signed general consent form. For members under the age of eighteen (18), the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05 (C) and (D) will give general consent for treatment. The provider will need to demonstrate this consent within the medical record via a signed general consent form by the legal representative.

Prior to signing the general consent form the member and/or legal representative must be fully informed of the consequences, benefits and risks of treatment and understands their rights not to consent to receive specific behavioral health services. Members over 18 years of age and/or the legal representative may refuse medications unless the member is required by a court order to take prescribed medications or in an emergency situation. Providers who are treating members in an emergency situation are not required to obtain general consent prior to treatment.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for psychotropic medication are contained in a sample form that can be accessed online at www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310V1.pdf. The use of the sample form is recommended as a tool to document informed consent for psychotropic medications.

19. RISK ADJUSTMENT ACCURACY AND COMPLETENESS

What is Risk Adjustment?

CMS defines risk adjustment as a process that helps 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 members who have chronic conditions.

Your Role as a Provider

As a provider, your complete and accurate documentation in a member's medical record and submitted claims are critical to a member's quality of care. We encourage providers to code all diagnoses to the highest specificity as this will ensure Molina receives adequate resources to provide quality programs to you and our members.

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

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina and reviewed with the member
- Be compliant with CMS correct coding initiative
- Use the correct ICD-10 code by coding the condition to the highest level of specificity
- Only use diagnoses codes confirmed during a provider visit with a 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

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.

Interoperability

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

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

The provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

If the Provider does not have 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 the Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

Contact Information

For questions about Molina's risk adjustment programs, please contact your Molina provider services representative.