Provider Newsletter

For Molina Healthcare of Nebraska, Inc. providers

June 2025

In this issue

MOLINA® HEALTHCARE | HERITAGE HEALTH

The provider newsletter is available to all network providers serving Molina Healthcare of Nebraska, Inc. members.

Important message: Updating provider information

Molina Healthcare of Nebraska, Inc. (Molina) needs to keep our provider network information current.

Up-to-date provider information allows Molina to accurately generate provider directories, process claims, and communicate with our provider network. Providers must update their changes on the Nebraska Department of Health and Human Services (DHHS) provider data management system (Maximus) and notify Molina in writing at least 30 days in advance, when possible, of changes, such as:

- Change in practice ownership or Taxpayer Identification Number (TIN)
- A change in practice address, phone or fax numbers
- A change in practices office hours
- New office site location
- **Primary care providers (PCP) only:** If your practice opens or closes to new patients
- When a provider joins or leaves the practice

Please visit the **Nebraska DHHS Provider Data website** to make changes. All changes must also be submitted on a roster and emailed to **NEProviderRosters@MolinaHealthcare.com**.

Contact your Provider Relations representative if you have any questions. You can find their contact inforamtion on our **website**.

Practitioner credentialing rights: What you need to know

Molina must protect its members by assuring their care is of the highest quality.

One protection is assurance that Molina's providers have been credentialed according to the strict standards established by the state regulators and accrediting organizations. As a Molina provider, your responsibility includes full disclosure of all issues and timely submission of all credentialing and re-credentialing information.

Molina also has a responsibility to its providers to ensure that the credentialing information reviewed is complete and accurate. **As a Molina provider, you have the right to:**

- Strict confidentiality of all information submitted during the credentialing process
- Nondiscrimination during the credentialing process
- Be notified of information obtained during the credentialing process that varies substantially from what you submit
- Review information submitted from outside primary sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application—except for references, recommendations or other peer-review protected information
- Correct erroneous information
- Be informed of the status of your application upon request by calling the credentialing department at **(844) 782-2678**, Monday-Friday, 7 a.m.- 6 p.m. CT.
- Receive notification of the credentialing decision within 60 days of the credentialing application
- Receive notification of your provider's right to appeal an adverse decision made by the committee
- Be informed of the above rights

For further details on your rights as a Molina provider, please review our **Provider Manual**. You also can contact Provider Services at **(844) 782-2678,** Monday-Friday, 7 a.m.-6 p.m. CT.

Molina's utilization management

One of the goals of our utilization management (UM) department is to render appropriate UM decisions consistent with objective clinical evidence.

To achieve this goal, we maintain the following guidelines:

- Our highly trained UM staff evaluates medical information received by our providers against nationally recognized, objective and evidence-based criteria. We also consider individual circumstances (at minimum age, comorbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable) and the local delivery system when determining the medical appropriateness of requested health care services.
- Molina's clinical criteria include:
  - Milliman Care Guidelines (MCG) criteria that are utilized to conduct inpatient review, except when Change Healthcare InterQual® is contractually required.
  - American Society of Addiction Medicine (ASAM) criteria
  - National Comprehensive Cancer Network® (NCCN)
  - Hayes Directories
  - Applicable Medicaid guidelines
  - Molina Clinical Policy (MCP)
  - Molina Clinical Review (MCR) (developed by designated corporate medical affairs staff in conjunction with Molina physicians serving on the Medical Coverage Guidance Committee)
  - UpToDate®
  - Other nationally recognized criteria, including technology assessments and well-controlled studies that meet industry standards and Molina policy; and when appropriate, third-party board-certified physician reviewers.

- Molina ensures all criteria used for UM decision-making are available to providers upon request. The clinical policy website, **MolinaClinicalPolicy.com**, provides access to MCP and MCR criteria. Providers also can access MCG Cite for Care Guideline Transparency tool through our Availity Essentials (Availity). To obtain a copy of the UM criteria, call our UM department Monday-Friday, 8 a.m.-6 p.m. CT at **(844) 782-2678**.
- As the requesting provider, you will receive written notification of all UM denial decisions. If you need assistance contacting a medical reviewer about a case, please call the UM department at **(844) 782-2678**, Monday-Friday, 8 a.m.-6 p.m. CT.

Molina wants to remind our providers that UM decision-making is based only on the appropriateness of care and service and the existence of coverage.

- Molina does not explicitly reward providers or other individuals for issuing denials of coverage or care.
- UM decision-makers do not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.
- Providers may freely communicate with patients about their treatment – regardless of benefit coverage.
- Medicaid members have the right to a second opinion from a qualified provider. If an appropriate provider is unavailable in-network, Molina will arrange for a member to obtain a second opinion out-of-network at no additional cost to the member. Members from all Molina lines of business and programs should refer to their benefit documents (such as schedule of benefits and/or evidence of coverage) for second-opinion coverage benefit details, limitations and cost-share information. If an appropriate provider is unavailable in-network, prior authorization (PA) is required to obtain the second opinion of an out-of-network provider. Claims for out-of-network providers that do not have a PA will be denied unless regulation dictates otherwise. All diagnostic testing, consultations, treatments and/or surgical procedures must be a benefit under the plan and meet all applicable medical necessity criteria to be covered.
- Some of the most common reasons for a delay or denial of a request include:
  - Insufficient or missing clinical information to provide the basis for making the decision
  - Lack of or missing progress notes or illegible documentation

Molina's UM department staff is available for inbound collect or toll-free calls during regular business hours to provide information about the UM process and the authorization of care. If you wish to speak with a UM staff member, please call **(844) 782-2678**, Monday-Friday, 8 a.m.-6 p.m. CT. You may also fax a question about a UM issue to **(833) 832-1015**. Molina's medical director is available to answer more complex medical decision questions and explain medical necessity denials.

Providers can quickly and conveniently submit and status check PA through the Availity provider portal.

Molina PA fax numbers include:

- Advanced imaging: **(877) 731-7218**
- Medicaid: **(833) 832-1015**

Please refer to the Drug formulary and pharmaceutical procedures article for information about Molina's formulary PA and the exception process.

Molina's regular business hours are Monday-Friday (excluding holidays), 8 a.m.-6 p.m. CT. Voicemail messages and faxes received after regular business hours will be returned the following business day. Molina has language assistance and TDD/TTY services for members with language barriers, members who are deaf or hard of hearing and those with speech impairment.

Drug formulary and pharmaceutical procedures

At Molina, the drug formulary – sometimes referred to as a Preferred Drug List (PDL) – and pharmaceutical procedures are maintained by the National Pharmacy and Therapeutics (P&T) Committee. This committee meets quarterly or more frequently if needed.

The P&T committee is responsible for developing and updating drug formularies that promote safety, effectiveness and affordability where state regulations allow. The committee objectively reviews new Food and Drug Administration (FDA) approved drugs, drug classes, new clinical indications for existing drugs, new line extensions and generics, new safety information, new clinical guidelines and practice trends that may impact previous formulary placement decisions. Additional committee oversight includes PA, step therapy, quantity limits, generic substitutions, medical exception protocols to allow coverage for non-formulary drugs, other drug utilization management activities that affect access, drug utilization evaluations and intervention recommendations for Molina health plans. Drug formulary activities include prescriber-administered specialty medications as a medical benefit and pharmacy benefit services.

The drug formularies reviewed and approved by the P&T Committee are updated quarterly and include an explanation of quantity limits, age restrictions, therapeutic class preferences and step therapy protocols. These changes and all current documents are posted on our **website**.

Providers may request a formulary exception for coverage of a drug outside of the drug formulary restrictions. A formulary exception should be requested to obtain a drug not included on a member's drug formulary or to request that a UM requirement be waived (e.g., step therapy, PA, quantity limit) for a formulary drug. Select medications on the drug formulary, or those not listed may require PA. PA requires that a prescriber obtains advance approval from Molina before a specific drug is prescribed to a member to qualify for payment coverage. The drug formulary/PDL is available on our website.

The P&T committee also promotes member safety. In the event of a Class II recall or voluntary drug withdrawal from the market for safety reasons, affected members and prescribing providers will be notified by Molina within 30 calendar days of the FDA notification. An expedited process is in place to ensure notification to affected members and providers of Class I recalls as quickly as possible. These notifications will be sent by fax, mail and/or via telephone.

Case management

Molina offers you and your patients the opportunity to participate in our complex case management program. Members must have the most complex service needs for this voluntary program. This may include members with multiple medical conditions, high levels of dependence, conditions that require care from multiple specialties and/or additional social, psychosocial, psychological and emotional issues that exacerbate their condition, treatment regime and/or discharge plan.

The purpose of the Molina complex case management program is to:

- Conduct a needs assessment of the patient, the patient's family and/or caregiver
- Provide intervention and care coordination services within the benefit structure across the continuum of care
- Empower our members to optimize their health and level of functioning
- Facilitate access to medically necessary services and ensure they are provided at the appropriate level of care promptly
- Provide a comprehensive and ongoing care plan for continuity of care in coordination with the member, the member's family, the provider and the provider's staff

If you would like to learn more about this program, you can speak with a complex case manager and/or refer a member for an evaluation by calling **(844) 872-2018**, Monday-Friday, 8 a.m. to 6 p.m. CT. You may also submit referrals by emailing **NE_CM@MolinaHealthcare.com**.

Resources available on Molina's provider website

Featured online at **Molinahealthcare.com/providers/ne/medicaid**:

- Clinical practice and preventive health guidelines
- Health management programs
- Quality improvement programs
- Member rights and responsibilities
- Privacy notices
- Provider Manual
- Current formulary
- Cultural competency provider trainings

If you would like to receive any of the information posted on our website in a printed format, please call **(844) 782-2678**, Monday-Friday, 7 a.m.-6 p.m. CT.

Translation Services

Molina can provide information in our members' primary language. We can arrange an interpreter to help you speak with our members in almost any language. We also provide written materials in different languages and formats. If you need an interpreter or written materials in other languages, please contact Molina at **(844) 782-2018**, Monday-Friday, 8 a.m.-6 p.m. CT. You can also call TTD/TTY: 711 if a member has a hearing or speech disability.

Patient safety

Patient safety activities encompass appropriate safety projects and error avoidance for Molina members in collaboration with their PCPs.

The MHC patient safety activities address the following:

- Continued information about safe office practices
- Member education about members taking an active role in reducing the risk of errors in their care
- Member education about safe medication practices
- Cultural competency training
- Improvement in the continuity and coordination of care between providers to avoid miscommunication
- Improvement in the continuity and coordination between care sites, such as hospitals and other facilities, to ensure timely and accurate communication

MHC also monitors nationally recognized quality index ratings for facilities from:

- Leapfrog Quality Index Ratings (**leapfroggroup.org**)
- The Joint Commission Quality Check® (**qualitycheck.org**)

Providers also can access the following links for additional information on patient safety:

- The Leapfrog Group (**leapfroggroup.org**)
- The Joint Commission (**jointcommission.org**)

Nondiscrimination

All providers joining the Molina provider network must comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS), the Office for Civil Rights (OCR), state law and federal program rules prohibiting discrimination. For additional information, please refer to the **Provider Manual** and/or the **Member Handbook**.

Additionally, participating providers or contracted medical groups/Independent Physician Associations (IPAs) may not limit their practices because of a member's medical (physical or mental) condition or the expectation for frequent or high-cost care.

Member rights and respsonsibilities

Molina wants to inform its providers about some of the rights and responsibilities of Molina members. For a complete list, please refer to the **Provider Manual** located on the provider website.

Molina members have the right to:

- Receive information about Molina, its services, its practitioners and providers, and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and their right to privacy.
- Help make decisions about their health care.
- Participate with providers in making decisions about their healthcare.
- A candid discussion of appropriate or medically necessary treatment options for their conditions – regardless of cost or benefit coverage.
- Voice complaints or appeals about Molina or the care provided.
- Make recommendations regarding Molina member rights and responsibilities policy.

Molina members have the responsibility to:

- Supply information (to the extent possible) that Molina and its practitioners and providers need to provide care.
- Follow plans and instructions for care that they have agreed to with their practitioners.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Keep appointments and be on time (If members are going to be late or cannot keep an appointment, they are instructed to call their practitioner.).

Call your provider's office at least 24 hours in advance if your appointment must be rescheduled. You can find your state's complete Member Rights and Responsibilities Statement on our website. Written copies and more information can be obtained by contacting Provider Services at **(844) 782-2678**, Monday-Friday, 7 a.m.-6 p.m. CT.

Population Health

(Health education, disease management, care management and complex case management)

The tools and services described here are educational support for our members. We may change them at any time necessary to meet our members' needs.

Molina offers programs to help our members and their families manage a diagnosed health condition. As a provider, you also help us identify members who may benefit from these programs. Members can request to be enrolled or disenrolled in these programs. Our programs include:

- Asthma management
- Diabetes management
- High blood pressure management
- Cardiovascular disease (CVD) management/congestive heart disease
- Chronic obstructive pulmonary disease (COPD) management
- Depression management
- High-risk obstetrician-gynecologist (OB/GYN) case management
- Transition of care (TOC)

You can find more information about our programs **online**.

If you have additional questions about our programs, please call Member Services at **(844) 782-2018** (TTY: 711), Monday-Friday, 8 a.m.-6 p.m. CT, excluding major holidays.

Quality improvement program

Molina's Quality improvement (QI) program provides the structure and key processes that enable the health plan to carry out our commitment to ongoing improvement in members' health care and service. The QI committee assists the organization in achieving these goals. It is an evolving program responsive to the changing needs of Molina's members and the standards established by the medical community and regulatory and accrediting bodies.

The key quality processes include but are not limited to:

- Implementation of programs and processes to improve members' outcomes and health status
- Collaboration with our contracted provider network to identify relevant care processes, develop tools and design meaningful measurement methodologies for provided care and service
- Evaluation of the effectiveness of programs, interventions and process improvements and determination of further actions
- Design of effective and value-added interventions
- Continuous monitoring of performance parameters and comparing to performance standards and benchmarks published by national, regional or state regulators, accrediting organizations and internal Molina thresholds
- Analysis of information and data to identify trends and opportunities and the appropriateness of care and services
- Oversight and improvement of functions that may be delegated: claims, UM and/or credentialing
- Confirmation of the quality and adequacy of the provider and health delivery organization network through appropriate contracting and credentialing processes

The QI program promotes and fosters accountability of employees, networks and affiliated health personnel for the quality and safety of care and services provided to Molina members.

The effectiveness of QI program activities in producing measurable improvements in the care and service provided to members is evaluated by:

- Organizing multi-disciplinary teams – including clinical experts – to analyze service and process improvement opportunities, determine actions for improvement and evaluate results
- Tracking the progress of quality activities and goals through appropriate quality committee minutes and reviewing/updating the quality work plan quarterly
- Revising interventions based on analysis when indicated
- Evaluating member satisfaction with their experience of care through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey
- Reviewing member satisfaction with their experience with behavioral health services through survey questions and/or evaluation of behavioral health-specific complaints and appeals
- Conducting provider satisfaction surveys with specific questions about the UM process, such as determining the level of satisfaction with getting a service approved, obtaining a referral and case management

Molina would like to help you promote the important care activities you have undertaken in your practices. If you would like to have your projects and programs highlighted on the Molina website, please contact the Provider Services at **(844)-782-2678**, Monday-Friday, 7 a.m.-6 p.m. CT.

If you want more information about our QI program or initiatives and the progress toward meeting quality goals, you can visit our **website** and access the Health Resources area on our provider website pages. If you would like to request a paper copy of our documents, please call Provider Services.

Standards for medical record documentation

Molina has established medical record documentation standards to help assure our members' highest quality of care. Medical record standards promote quality care through communication, coordination and continuity of care and efficient and effective treatment.

Molina's medical record documentation standards include:

- Medical record content
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records
- Confidential patient information
- Standards and performance goals for participating providers

The following items must be included in each medical record:

- Member-identifying information, including name, member ID number, date of birth, gender, and legal guardianship (if applicable)
- Primary language spoken by the member and any translation needs
- Services provided through the MCO, date of service, service site, and name of service provider
- Medical history, diagnoses, treatment prescribed, therapy prescribed, and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by Molina Healthcare of Nebraska
- Referrals including follow -up and outcome of referrals
- Documentation of emergency or after-hours encounters and follow-up
- Signed and dated consent forms
- Documentation of immunization status
- Documentation of advance directives, as appropriate
- Documentation of each visit must include:
  - Date and beginning and end times of service
  - Chief complaint or purpose of the visit
  - Diagnoses or medical impression
  - Objective findings
  - Patient assessment finding
  - Studies ordered and results

For more information, please call the Provider Services at **(844) 782-2678**, Monday-Friday, 7 a.m.-6 p.m. CT.

Preventive health guidelines

Preventive health guidelines can be beneficial to providers and our members. Guidelines are based on scientific evidence, a review of the medical literature or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations.

These guidelines are meant to recommend a standard level of care and do not preclude the delivery of additional preventive services based on the member's needs.

You can also view all **Preventive Health Guidelines** by accessing the Health Resources section within our provider web pages. To request printed copies of preventive health guidelines, please contact Provider Services at **(844) 782-2678**, Monday to Friday, 7 a.m. to 6 p.m. CT.

Clinical health guidelines

Clinical practice guidelines are based on scientific evidence, a review of the medical literature or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The care recommendations are suggested as guides for making clinical decisions. Providers and our members must work together to develop individual treatment plans tailored to each member's needs and circumstances.

Molina has adopted the following Clinical Practice and Behavioral Health Guidelines, which include but are not limited to:

- 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
- Depression
- Diabetes
- Heart failure in adults
- Homelessness – special health care needs
- Hypertension
- Obesity
- Opioid management
- Perinatal care
- Pregnancy management
- Schizophrenia
- Sickle cell disease
- Substance use disorder (SUD)
- Suicide risk
- Trauma-informed primary care

You can also view all **Clinical Practice Guidelines** online in the Health Resources section of the provider web pages. To request a copy of any guidelines, please contact the Provider Services at **(844) 782-2678**, Monday to Friday, 7 a.m. to 6 p.m. CT.

Advance directives

Providers can assist Molina members in preparing an advance directive. Anyone 18 or older can have an advance directive, including a living will and a durable power of attorney.

A living will is written instruction explaining the wishes of a Molina member regarding health care in the case of a terminal illness or any medical procedures that can prolong life. A durable power of attorney names a person to make decisions for our members if they cannot.

The following links provide free forms and information to help create an advance directive:

- **caringinfo.org**
- **nlm.nih.gov/medlineplus/advancedirectives.html**

Members will need two witnesses for the living will document and valid notarization for the durable power of attorney document.

An advance directive must be honored to the fullest extent permitted under law. Providers should discuss advance directives and provide appropriate medical advice if the member desires guidance or assistance, including any objections they may have to a directive before service whenever possible. Providers cannot refuse treatment or otherwise discriminate against members because they completed an advance directive. Members have the right to file a complaint if they are dissatisfied with the handling of an advance directive and/or if there is a failure to comply with advance directive instructions.

Providers should put a copy of the completed form in a prominent medical record section. The medical record should also document if a member chooses not to execute an advance directive. Providers should inform members that advance care planning is a part of good health care.

Behavioral health

PCPs provide outpatient behavioral health services by coordinating their practice's scope and coordinating members' physical and behavioral health care.

Behavioral health services are a direct access benefit and are available with no referral required; however, PCPs are responsible for coordinating a referral if needed. If you or the member need assistance with obtaining behavioral health services, please contact Member Services at **(844) 782-2018**, Monday–Friday, 8 a.m.–6 p.m. CT.

Our 24-hour Nurse Advice Line is also available to members 24 hours a day, 7 days a week, 365 days per year for mental health or substance use disorder and can be reached by calling **(844) 782-2721** (TTY: 711). The services received will be confidential.

Providers may refer to the Molina **Behavioral Health Toolkit** online for additional clinical guidance, recommendations and training/education opportunities related to behavioral health conditions. Providers can locate the **Behavioral Health Toolkit** for providers under the **Provider Resources** tab on our **website**.

Care coordination and transitions

Coordination of care during planned and unplanned transitions for MHC members

Molina is dedicated to providing quality care for our members during planned or unplanned transitions. A transition is when members move from one setting to another, such as when a member is discharged from a hospital. By working with providers, Molina makes a special effort to coordinate care during transitions to avoid potential adverse outcomes.

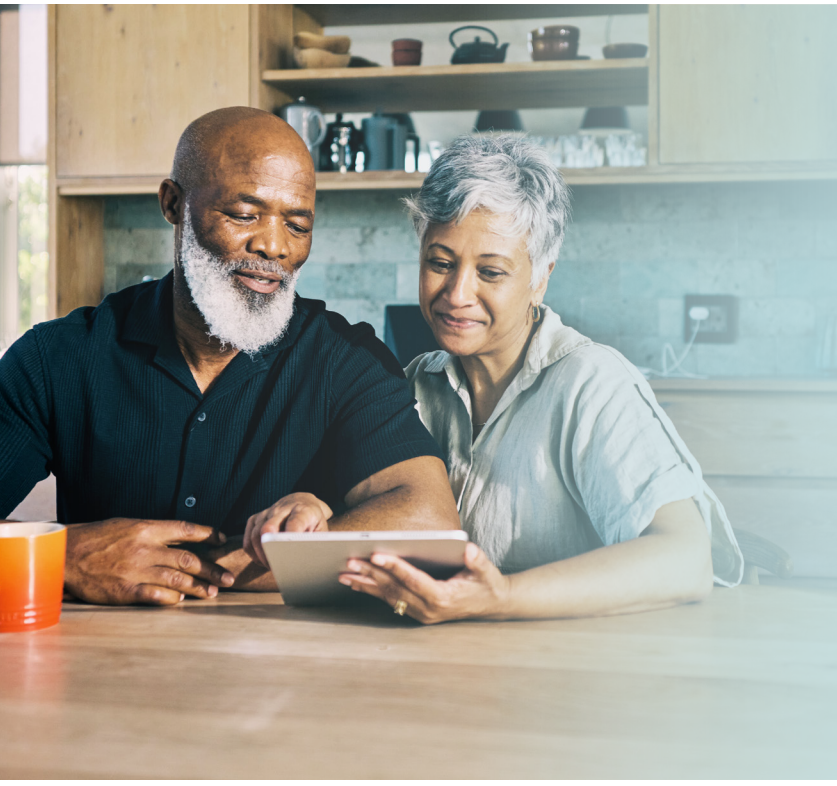
Molina has resources to assist you in easing the challenge of coordinating patient care. Our staff – including nurses – can work with all parties to ensure appropriate care.

To appropriately coordinate care, we'll need the following information in writing from the facility ***within one business day*** of the transition from one setting to another:

- Discharge plan when the member is transferred to another setting
- A copy of the member's discharge instructions when discharged to home

This information should be faxed to MHC at:

- UM department: **(866) 553-9623**
- Member Services: **(800) 811-4804 (TTY/TDD: 711)**



Health Risk Screener and self-management tools

We provide members with a Health Risk Screener (health appraisal) on the My Molina® member portal. Our members are asked questions about their health and behaviors and receive a report about possible health risks. A self-management tool is also available to offer guidance for weight management, depression, financial wellness and various other topics. Members can access these tools online at **MyMolina.com.** Members who complete the screener within their first 90 days of becoming a Molina member will receive a Healthy Reward.

We're here for you.

You can count on us to support you. Contact us whenever you need help.

Claims
Availity Essentials Portal
(800) 282-4548
Monday-Friday
7 a.m.-7 p.m. CT

Compliance 24/7 Alertline
(866) 606-3889
Report fraud, waste and abuse
24 hours a day, 7 days a week,
365 days a year

Contracting
NEContracting@MolinaHealthcare.com

Member Services
(844) 782-2018 (TTY: 711)
Monday-Friday
8 a.m.-6 p.m. CT

Molina Dental Services
MDVSProviderServices@MolinaHealthcare.com

Provider Contact Center
(844) 782-2678
Monday-Friday
7 a.m.-6 p.m. CT

Provider Relations
NEProviderRelations@MolinaHealthcare.com

SkyGen Provider Services
(855) 806-5192
Monday-Friday
7 a.m.-8 p.m. CT

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