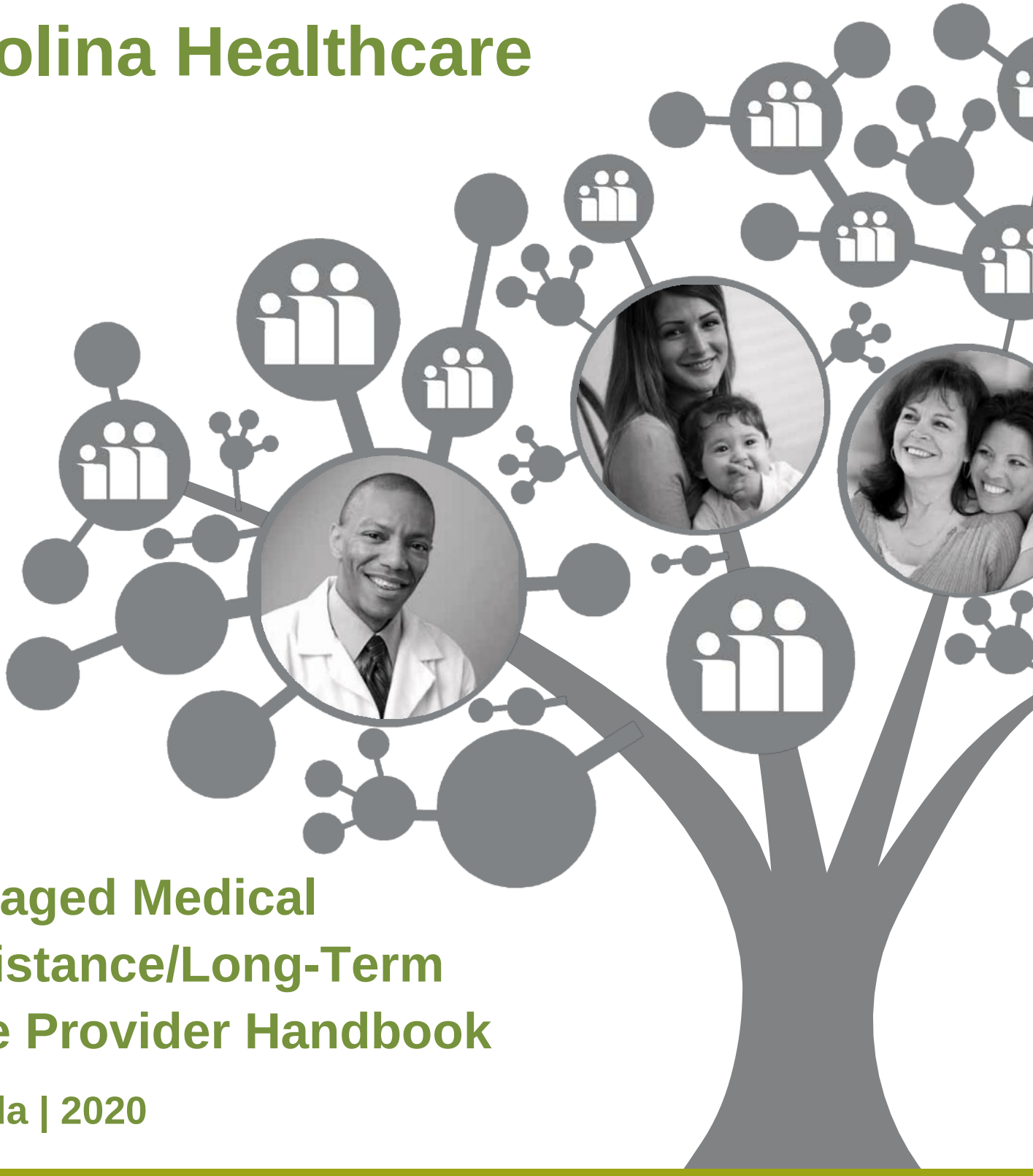
Molina Healthcare



Managed Medical Assistance/Long-Term Care Provider Handbook

Florida | 2020

MOLINA® HEALTHCARE

Your Extended Family.

Contents

Addresses and Phone Numbers

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8:00 AM to 7:00 PM EST/EDT Monday through Friday, excluding State holidays.

Member Services	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(866) 472-4585
TTY:	(800) 955-8771 (English) (800) 955-8773 (Spanish)

Claims Department

The Claims Department is located at our corporate office in Long Beach, CA. Molina requests Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal). All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use EDI Claims/ Payor ID number - 51062.

To verify the status of your claims, please visit the Provider Portal or call our Provider Claims Representatives at the numbers listed below.

Claims	
Address:	Molina Healthcare of Florida PO Box 22812 Long Beach, CA 90801
Phone:	(855) 322-4076
TTY:	(800) 955-8771 (English) (800) 955-8773 (Spanish)
Provider Portal	
https://provider.molinahealthcare.com	

Claims Recovery Department

The Claims Recovery Department manages recovery for overpayment and incorrect payment of claims.

Claims Recovery	
Address:	Molina Healthcare of Florida (Recovery Lockbox) Atlanta, GA 30374-1037
Phone:	(866) 642-8999
Fax:	(888) 396-1121

Credentialing Department

The Credentialing Department verifies all information on the Practitioner Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina Healthcare network. The Credentialing Department also performs office and medical record reviews.

Credentialing	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(855) 322-4076
Fax:	(866) 422-6445

Health Line (24-Hour Nurse Advice Line)

This telephone-based nurse advice line is available to all Molina Healthcare 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 to assess symptoms and help make good health care decisions.

HEALTHLINE **(24-Hour Nurse Advise Line)**
English Phone: (888) 275-8750 Spanish Phone: (866) 648-3537
TTY: (866) 735-2929 (English) (866) 833-4703 (Spanish)

Healthcare Services Department

The Healthcare Services Department conducts concurrent review on inpatient cases and processes Prior Authorization requests.

Healthcare Services **Authorizations & Inpatient Census**	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(855) 322-4076
Fax:	(866) 440-4791

Health Education & Health Management Department

The Health Education and Health Management Department provides education and health information to Molina Healthcare Members and facilitates Provider access to the programs and services.

Health Education & Management	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(855) 322-4076
Fax:	(866) 422-6445

Behavioral Health

Beacon Health Options manage all components of behavioral health for Molina Healthcare Members.

Beacon Health Options	
Address:	Beacon Health Options 200 State Street Boston, MA 02109
Phone:	1-855-371-3945
(24) Hours per day, (365) day per year	

Compliance Department

Molina Healthcare's Compliance Department can be reached at the number provided below:

Compliance Hotline
Phone: (866) 642-9510

Abuse, Neglect and Exploitation Hotline

To report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult, please contact the Florida Abuse Hotline toll-free telephone number.

Florida Abuse Hotline
(800)-96ABUSE or (800)-962-2873

Pharmacy Department

Molina Healthcare's drug formulary requires Prior Authorization for certain medications including injectable medications. The Pharmacy Department can answer questions regarding the formulary and/or drug Prior Authorization requests. They will also facilitate the services of Caremark Pharmacy Services for injectable medications. The Molina Healthcare formulary is available at www.molinahealthcare.com.

Pharmacy Authorizations	
Phone:	(800) 791-6856
Fax:	(866) 236-8531

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, provider denied claims review, contracting, and training. The department has Provider Services Representatives serving all Molina Healthcare of Florida's provider network.

Provider Services	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(855) 322-4076
Fax:	(866) 948-3537

Vision Care

Molina Healthcare is contracted with iCare Solutions to provide routine vision services for our Members. Members who are eligible may directly access a vision care network Provider.

iCare Solutions	
Address:	iCare Solutions Attn: Claims 7352 NW 34th Street Miami, FL 33122
Phone:	(855) 373-7627

Therapy Vendor (PT/OT/ST)

Molina Healthcare is contracted with American Therapy Administrators/Health Network One (ATA-FL/HN1) to provide freestanding therapy services (***PT/OT/ST***) for our MMA Members.

American Therapy Administrators/Health Network One	
Address:	American Therapy Administrators of FL/Health Network One PO Box 350590 Fort Lauderdale, FL 33335-0590
Phone:	(888) 550-8800

Therapy Vendor (Art/Pet Therapy)

Molina Healthcare is contracted with Medical Transportation Management to provide freestanding therapy services (***Art & Pet Therapy***) for our MMA Members.

Medical Transportation Management	
Address:	635 Maryville Centre Drive St. Louis, Missouri 63141
Phone:	(888) 521-2651

Coastal Care Services

Molina Healthcare is contracted with Coastal Care Services to provide Home Health, Home Infusion, and DME services for our MMA Members.

Coastal Care Services	
Address:	Coastal Care Services, Inc. Attn: Claims Department 7875 NW 12th Street, Suite 200 Doral, FL 33126
Phone:	(855) 481-0505

Enrollment, Eligibility and Disenrollment

Enrollment in Medicaid Programs

Medicaid is the medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency for Healthcare Administration under s. 409.901 et seq., F.S. It is the state and federal system of health insurance that provides health coverage for eligible children, seniors, disabled adults and pregnant women.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: one for Managed Medical Assistance (MMA) and one for Long-Term Care (LTC).

The State of Florida (State) has the sole authority for determining eligibility for Medicaid. The Department of Children and Families acts as the Agency's agent by enrolling recipients in Medicaid. The agency shall have the sole authority for determining whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Managed Care Plan or are subject to annual open enrollment. The Agency or its agent(s) shall be responsible for enrollment, including algorithms to assign mandatory potential enrollees, and disenrollment, including determinations regarding involuntary disenrollment, in accordance with this Contract.

The Agency shall be responsible for the operations of the Florida Medicaid Management Information System (FMMIS) and contracting with the state's fiscal agent to exchange data with Managed Care Plans, enroll Medicaid providers, process Medicaid claims, distribute Medicaid forms and publications, and send written notification and information to all potential enrollees.

Only Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services from the Managed Care Plan. Each recipient shall have a choice of Managed Care Plans and may select any authorized Managed Care Plan unless the Managed Care Plan is restricted to a specific population that does not include the recipient.

Medicaid recipients who qualify and become enrolled in the Florida Long Term Care Managed Care Program will receive long term care services that will be managed through a case manager of the health plan. The health plan will work with different providers to offer quality health care services and to ensure enrollees have access to covered services as needed.

The Managed Care Plan may not impose enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider; Indian Health Service; an Indian Tribe, Tribal Organization, or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009

The Agency or its agents will notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan. The Agency or its enrollment broker will send written confirmation to enrollees of the chosen or assigned Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer.

Recipients in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan:

(1) Temporary Assistance to Needy Families (TANF);

(2) SSI (Aged, Blind and Disabled);

(3) Hospice;

(4) Low Income Families and Children;

(5) Institutional Care;

(6) Medicaid (MEDS) - Sixth Omnibus Budget Reconciliation Act (SOBRA) for children born after 9/30/83 (age 18 to 19);

(7) MEDS AD (SOBRA) for aged and disabled;

(8) Protected Medicaid (aged and disabled);

(9) Full Benefit Dual Eligibles (Medicare and Medicaid -FFS);

(10) Full Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Plans that are not fully liable for all Medicaid services covered under the current SMMC Contract; and

(11) The Florida Assertive Community Treatment Team (FACT Team).

(12) Title XXI MediKids; and

(13) Children between 100 - 133% of federal poverty level (FPL) who transfer from the state's Children's Health Insurance Program (CHIP) to Medicaid; and

(14) MEDS (SOBRA) for children under one (1) year old and income between 185 - 200% FPL.

Voluntary Enrollment

Certain recipients may voluntarily enroll in a Managed Care Plan to receive services. These recipients are not subject to mandatory open enrollment periods.

In addition to the programs and eligibility categories specified, recipients in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan:

1. SSI (enrolled in developmental disabilities home and community based waiver);

2. MEDS AD – (SOBRA) for aged and disabled – enrolled in DD home and community based waiver;
3. Recipients with other creditable coverage excluding Medicare;
4. Recipients age sixty-five (65) and older residing in mental health treatment facilities as defined in s. 394.455(47), F.S.;
5. Residents of DD centers including Sunland and Tachacale;
6. Refugee assistance;
7. Recipients residing in group homes licensed under Chapter 393, F.S.; and
8. Children receiving services in a prescribed pediatric extended care center (PPEC).

Excluded Populations

The following Medicaid recipients are not eligible to enroll in a Medicaid Managed Care Plan:

(1) Presumptively eligible pregnant women;
(2) Family planning waiver;
(3) Women enrolled through the Breast and Cervical Cancer Program;
(4) Emergency shelter/Department of Juvenile Justice (DJJ) residential;
(5) Emergency assistance for aliens;
(6) Qualified Individual (QI);
(7) Qualified Medicare beneficiary (QMB) without other full Medicaid coverage;
(8) Special low-income beneficiaries (SLMB) without other full Medicaid coverage;
(9) Working disabled;
(10) Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Dual Special Needs Plans; and

(11) Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Plans that are fully liable for all Medicaid services covered in the current SMMC contract.
(12) Recipients eligible for the Medically Needy program;

In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a Managed Care Plan:

- Recipients in the Health Insurance Premium Payment (HIPP) program

Enrollment and Eligibility for Home & Community Based Services

Eligible recipients age eighteen (18) years or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

(1) Temporary Assistance to Needy Families (TANF);

(2) SSI (Aged, Blind and Disabled);

(3) Institutional Care;

(4) Hospice;

(5) Individuals who age out of Children's Medical Services and meet the following criteria:

(a) Received care from Children's Medical Services prior to turning age twenty-one (21) years;

(b) Age twenty-one (21) years and older;

(c) Cognitively intact;

(d) Medically complex; and

(e) Technologically dependent.

(6) Low Income Families and Children;

(7) MEDS (SOBRA) for children born after 9/30/83 (age eighteen (18) through twenty (20) years);

(8) MEDS AD (SOBRA) for aged and disabled;

(9) Protected Medicaid (aged and disabled);

(10) Full Benefit Dual Eligibles (Medicare and Medicaid);

(11) Individuals enrolled in the Frail/Elderly Program component of United Healthcare HMO; and

(12) Medicaid Pending for Long-term Care Managed Care HCBS waiver services.

Voluntary Enrollment

Eligible recipients eighteen (18) years or older in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

a. Traumatic Brain and Spinal Cord Injury waiver;
b. Project AIDS Care (PAC) waiver;
c. Adult Cystic Fibrosis waiver;
d. Program of All-Inclusive Care for the Elderly (PACE) plan members;
e. Familial Dysautonomia waiver;
f. Model waiver (age eighteen (18) through twenty (20) years);
g. Developmental Disabilities waiver (iBudget and Tiers 1-4);
h. Medicaid for the Aged and Disabled (MEDS AD) — Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled — enrolled in Developmental Disabilities (DD) waiver; and
i. Recipients with other creditable coverage excluding Medicare.

Excluded Population

Regardless of eligibility category, the following recipients are excluded from enrollment in a Comprehensive LTC Managed Care Plan:

(1) Recipients residing in residential commitment facilities operated through DJJ or treatment facilities as defined in s. 394.455(47), F.S.;

(2) Recipients residing in DD centers including Sunland and Tacachale;

(3) Children receiving services in a prescribed pediatric extended care center (PPEC);

(4) Children with chronic conditions enrolled in the Children's Medical Services Network; and

(5) Recipients in the Health Insurance Premium Payment (HIPP) program.

Effective Date of Enrollment

The Agency or its agents will notify the Managed Care Plan of an enrollee's selection or assignment to the Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer. Enrollment in the Managed Care Plan shall be effective at 12:01 a.m. on the

effective date of enrollment provided on the Enrollment File.

For MMA Managed Care Plans, if the enrollee has not chosen a PCP, the Agency's confirmation notice will advise the enrollee that a PCP will be assigned by the Managed Care Plan.

Conditioned on continued eligibility, mandatory Members will have a lock-in period of up to (12) consecutive month. After an initial (120) day change period, mandatory Members will only be able to disenroll from the Health Plan for cause. The Agency or its enrollment broker will notify Members at least once every (12) months and at least (60) calendar days prior to the date the lock-in period ends that an open enrollment period exits giving them the opportunity to change Managed Care Plans. Mandatory Members who do not make a change during open enrollment will be deemed to have chosen to remain with the current Managed Care Plan, unless that Managed Care Plan no longer participates. In that case, the Member will be transitioned to a new Managed Care Plan.

Enrollment in a Managed Care Plan may be effective on the first calendar day of the month following an approved plan change.

The Agency will automatically reinstate an enrollee into the Managed Care Plan in which the person was most recently enrolled if the enrollee has a temporary loss of eligibility. In this instance, for mandatory Members, the lock-in period will continue as though there had been no break in eligibility, keeping the original twelve- (12) month period. For MMA Managed Care Plans, the "temporary loss period" is defined as no more than one hundred and eighty (180) calendar days. If a temporary loss of eligibility causes the enrollee to miss the open enrollment period, the Agency will enroll the person in the Managed Care Plan in which he or she was enrolled before loss of eligibility. The enrollee will have one hundred and twenty (120) calendar days from enrollment to disenroll without cause.

Newborn Enrollment

Molina Healthcare shall be responsible for newborns of pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.

Failure to comply with the procedures, set forth by the Agency or its agent, related to the unborn activation and newborn enrollment process as specified by the Agency, may result in sanctions.

Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another plan or the newborn does not meet the enrollment criteria of the mother's plan. When a newborn does not meet the criteria of the mother's plan, the newborn will be enrolled in a plan in accordance with MMA guidelines.

Inpatient at time of Enrollment

Regardless of what program or Managed Care Plan the Member is enrolled in at discharge, the Managed Care Plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility services provided from the date of admission until the date the Member is discharged

Professional services rendered during the course of an inpatient admission are the responsibility of the Managed Care Plan in which the Member is enrolled on the date of service.

Eligibility Verification

Medicaid Programs

The Department of Children and Families (DCF) determines eligibility for Medicaid. Eligibility is determined on a monthly basis. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina Healthcare places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Medicaid Programs

Providers can verify eligibility for Medicaid Program recipients by calling the Automated Voice Response System (AVRS) at 800-239-7560 or by visiting the fiscal agent's website at http://mymedicaid-florida.com. When calling to verify a Member's eligibility, Providers will need their own NPI number AND 10-digit Taxonomy number OR Medicaid Provider ID number. They will also need the Member's 10-digit recipient number OR Social Security number AND Date of Birth OR 8-digit classic card control number.

Providers my also access recipient's eligibility information on the Medicaid Eligibility Verification System (MEVS) via the following:

- Provider Self Services Automated voice response (FaxBack) that generates a report with all the eligibility information for a particular recipient, which is automatically faxed to the provider's fax machine
- Automated voice response that provides eligibility information using a touch-tone telephone
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response

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

- Molina Healthcare Member Services at (866) 472-4585
- Molina Healthcare Web Portal, www.molinahealthcare.com

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.

Each Medicaid eligible recipient receives an individual identification card from DCF. The recipient is instructed to retain the card even during periods of ineligibility. If the recipient becomes ineligible for Medicaid and later becomes eligible, the same ID card is used.

The Florida Medicaid Identification card is a gold plastic card with a magnetically encoded stripe. Recipients who are eligible for MediKids have a blue and white plastic card with a magnetically encoded stripe.

The provider must submit a claim to the Managed Care Plan using the recipient's ten-digit Medicaid ID number. This number is not on the Medicaid identification card. The eight-digit number on the front of the Medicaid identification card is the card control number used to access the recipient's file and verify eligibility. It is not the recipient's ten-digit Medicaid identification number that is entered on claims for billing.

The provider may obtain this information by looking up the recipient's eligibility record on MEVS, Faxback, or AVRS using the card control number. The provider should record the recipient's Medicaid ID number obtained from the eligibility verification for billing purposes. The Medicaid ID number will be included on the valid proofs of eligibility.

All Members enrolled with Molina Healthcare receive an identification card from Molina Healthcare in addition to the Florida Medicaid ID card. Molina Healthcare sends an identification card for each family Member covered under the plan. Members are reminded in their Member Handbooks to carry both ID cards (Molina Healthcare ID card and Florida Medicaid card) with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Healthcare Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Molina Healthcare must not restrict the Member's right to disenroll voluntarily in any way. Neither it, nor its subcontractors, providers or vendors shall provide or assist in the completion of a disenrollment request or assist the Agency's enrollment broker in the Disenrollment process.

Members requesting disenrollment from Molina Healthcare must be referred to the Agency. Providers should inform Molina Healthcare in writing when a Member has been referred to the Agency's enrollment broker for disenrollment.

Disenrollment for No Cause

A mandatory Member subject to open enrollment may submit to the Agency or its enrollment broker a request to disenroll from Molina Healthcare without cause at the following times:

(1) During the one hundred and twenty (120) days following the enrollee's initial enrollment, or the date the Agency or its enrollment broker sends the enrollee notice of the enrollment, whichever is later;

(2) At least every twelve (12) months during a recipient's annual open enrollment period;

(3) During the one hundred and twenty (120) days following the enrollee's re-enrollment if a temporary loss of eligibility causes the enrollee to miss the open enrollment period;

(4) When the Agency or its enrollment broker grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); and

(5) During the thirty (30) days after the enrollee is referred for hospice services in order to enroll in another Managed Care Plan to access the enrollee's choice of hospice provider.

Voluntary enrollees not subject to open enrollment may disenroll without cause at any time.

Disenrollment for Good Cause

A mandatory Member may request disenrollment from Molina Healthcare for cause at any time. Such request shall be submitted to the Agency or its enrollment broker. The following reasons constitute cause for disenrollment from Molina Healthcare:

(1) The enrollee does not live in a region where the Managed Care Plan is authorized to provide services, as indicated in FMMIS.
(2) The provider is no longer with the Managed Care Plan.
(3) The enrollee is excluded from enrollment.
(4) A substantiated marketing or community outreach violation has occurred.
(5) The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
(6) The enrollee has an active relationship with a provider who is not on the Managed Care Plan's panel, but is on the panel of another Managed Care Plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.
(7) The enrollee is in the wrong Managed Care Plan as determined by the Agency.
(8) The Managed Care Plan no longer participates in the region.
(9) The state has imposed intermediate sanctions upon the Managed Care Plan, as specified in 42 CFR 438.702(a)(3).
(10) The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed Care Plan network, or the enrollee's PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.
(11) The Managed Care Plan does not, because of moral or religious objections, cover the service the enrollee seeks.
(12) The enrollee missed open enrollment due to a temporary loss of eligibility.

(13) Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee's health care needs; or fraudulent enrollment.

Voluntary enrollees may disenroll from Molina Healthcare at any time.

Involuntary Disenrollment

Under very limited conditions and in accordance with Agency guidelines, Members may be involuntarily disenrolled from Molina Healthcare. With proper written documentation and approval by the Agency, the following are acceptable reasons for which Molina Healthcare may submit involuntary disenrollment requests to the Agency or its enrollment broker, as specified by the Agency:

(1) Fraudulent use of the enrollee identification (ID) card. In such cases the Managed Care Plan shall notify MPI of the event.
(2) Falsification of prescriptions by an enrollee. In such cases the Managed Care Plan shall notify MPI of the event.
(3) The enrollee's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the Managed Care Plan seriously impairs the organization's ability to furnish services to either the enrollee or other enrollees.
    a) This provision does not apply to enrollees with medical or mental health diagnoses if the enrollee's behavior is attributable to the diagnoses.
    b) An involuntary disenrollment request related to enrollee behavior must include documentation that the Managed Care Plan:
        i. Provided the enrollee at least one (1) oral warning and at least one (1) written warning of the full implications of the enrollee's actions;
        ii. Attempted to educate the enrollee regarding rights and responsibilities;
        iii. Offered assistance through care coordination/case management that would enable the enrollee to comply;
        iv. Determined that the enrollee's behavior is not related to the enrollee's medical or mental health condition.

Molina Healthcare will not request disenrollment of an enrollee due to:

(1) Health diagnosis;
(2) Adverse changes in an enrollee's health status;
(3) Utilization of medical services;
(4) Diminished mental capacity;
(5) Pre-existing medical condition;
(6) Uncooperative or disruptive behavior resulting from the enrollee's special needs (with exceptions);

(7) Attempt to exercise rights under the Managed Care Plan's grievance system; or
(8) Request of a provider to have an enrollee assigned to a different provider outside of Molina Healthcare's provider network.

Molina Healthcare will not submit a disenrollment request to be effective later than forty-five (45) days after the Molina's receipt of the reason for involuntary disenrollment. The Managed Care Plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

Molina Healthcare will send written notification to the enrollee that the Managed Care Plan is requesting disenrollment, the reason for the request, and an explanation that the Molina is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary. Until the enrollee is disenrolled, Molina will be responsible for the provision of services to that enrollee.

PCP Dismissal

A PCP may dismiss a Member from his/her practice based on standard policies established by the PCP. Reasons for dismissal must be documented by the PCP and may include:

- For a Member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.
- For a Member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that the behavior seriously impairs the organization's ability to furnish services to either the Member or other Members. This Section does not apply to Members with mental health diagnoses if the Member's behavior is attributable to the mental illness.

Missed Appointments

The provider will document and follow up on appointments missed and/or canceled by the Member. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel. Such a request must be submitted at least (60) calendar days prior to the requested effective date. The provider agrees not to charge a Member for missed appointments.

A Member may only be considered for an involuntary disenrollment after the Member has had at least one (1) verbal warning and at least one (1) written warning of the full implications of his or her failure of actions. The Member must receive written notification in fourth grade reading level from the PCP explaining in detail the reasons for dismissal from the practice. Action related to request for involuntary disenrollment conditions must be clearly documented by providers in the Member's records and submitted to Molina Healthcare. The documentation must include attempts to bring the Member into compliance. A Member's failure to comply with a written corrective action plan must be documented. For any action to be taken, it is mandatory that copies of all supporting documentation from the Member's file are submitted with the request. Molina Healthcare will contact the Member to educate the Member of the consequences of behavior that is disruptive, unruly, abusive or uncooperative and/or assist the

Member in selecting a new PCP. The current PCP must provide emergency care to the Member until the Member is transitioned to a new PCP.

PCP Assignment

Molina Healthcare will offer each Member a choice of PCPs. After making a choice, each Member will have a single PCP. Molina Healthcare will assign a PCP to those Members who did not choose a PCP at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the Member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the Member's home address, zip code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender restrictions. Molina Healthcare will assign all Members that are reinstated after a temporary loss of eligibility to the PCP who was treating them prior to loss of eligibility, unless the Member specifically requests another PCP, the PCP no longer participates in Molina Healthcare or is at capacity, or the Member has changed geographic areas.

Molina Healthcare will allow pregnant Members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. Molina Healthcare shall assign a pediatrician or other appropriate PCP to all pregnant Members for the care of their newborn babies no later than the beginning of the last trimester of gestation. If Molina Healthcare was not aware that the Member was pregnant until she presented for delivery, it will assign a pediatrician or a PCP to the newborn baby within one (1) business day after birth. Providers shall advise all Members of the Members' responsibility to notify Molina Healthcare and their DCF public assistance specialists (case workers) of their pregnancies and the births of their babies.

PCP Changes

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

1. If a Member calls to make a PCP change prior to the 25th of the month, the Member will be allowed to retroactively change their PCP to be effective the first of the current month
2. If a Member calls to make a PCP change after the 25th of the month, the change will be made prospectively to be effective the first of the following month
3. If the Member was assigned to the incorrect PCP due to Molina Healthcare's error, the Member can retroactively change the PCP, effective the first of the current month.

Member Rights & Responsibilities

This section explains the rights and responsibilities of Molina Healthcare Members as written in the Molina Member Handbook. Florida law requires that health care providers or health care facilities recognize Member rights while they 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 patients. Members may request a copy of the full text of this law from their health care provider or health care facility.

Member Rights

As a recipient of Medicaid and a member in a Plan, you also have certain rights. You have the right to:

- Be treated with courtesy and respect
- Have your dignity and privacy respected at all times
- Get information about our organization, its services, its doctors and providers and members rights and responsibilities
- Make recommendations regarding our members rights and responsibilities policy
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given information about your diagnosis, the treatment you need, choices of treatments, risks, and how these treatments will help you, regardless of cost or benefit coverage
- Participate with your doctors in making decisions about your health care
- Say no any treatment, except otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can’t make them yourself (advanced directive)
- To file a grievance/complaint about any matter other than a Plan’s decision about your services

- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Get care without fear of restraint or seclusion used for bullying, discipline, convenience, or revenge
- Exercise these rights without changing the way Molina or its network providers treat you

LTC Members have the right to:

- Receive services in a home-like environment regardless where you live
- Receive information about being involved in your community, setting personal goals and how you can participate in that process
- Be told where, when and how to get the services you need
- To be able to take part in decisions about your health care
- To talk openly about the treatment options for your conditions, regardless of cost of benefit
- To choose the programs you participate in and the providers that give you care

Member Responsibilities

As a recipient of Medicaid and a member in a Plan, you also have certain responsibilities. You have the responsibility to:

- Give accurate information about your health to your Plan and providers, needed in order to provide care
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow plans and instructions for care that you have agreed to with your provider and ask questions
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- Keep your appointments or notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse and overpayment

LTC Members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-term care program

- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager

Benefits and Covered Services

Molina Healthcare shall provide the services listed below in accordance with the Florida Medicaid Coverage Policy, the Florida Medicaid Coverage and Limitations Handbooks, the Florida Medicaid fee schedules, and the provisions in its contract with the Agency. Molina Healthcare shall comply with all state and federal laws pertaining to the provision of such services. The following provisions highlight key requirements for certain covered services, including requirements specific to the MMA program.

For specific information about a covered service, please contact Member Services at (866) 472-4585.

Covered Services

The table below lists the medical services that are covered by our Plan. *(Please note: Services highlighted by an asterisk (*) are considered In-Lieu Of Services.)*

If you have questions about any of the covered medical services, please call Provider Services.

Service	Description	Coverage/Limitations	Prior Authorization
*Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots	Yes – **Excluded for Specialties**: *Allergists, Allergy & Immunolgists, Otolaryngologists, and Pulmonologists*
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary.	No
*Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility	Covered as medically necessary.	No

	that is not the hospital (outpatient)		
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	No
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year,	No
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover: - One initial assessment per year - One reassessment per year - Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program	We cover 365/366 days of services per year, including therapy, support services and aftercare planning	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*Behavioral Health Services – Child Welfare	A special mental health program to children enrolled in a DCF program	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor: - Cardiac testing - Cardiac surgical procedures - Cardiac devices	No
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services	Your child must be enrolled in the DOH Early Steps program	
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover: - One new patient visit - 24 established patient visits per year - X-rays	No
Clinic Services	Health care services provided in a county health department, federally qualified health		No

	center, or a rural health clinic		
*Community-Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor: - Hemodialysis treatments - Peritoneal dialysis treatments	No
*Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	Some service and age limits apply.	Yes – *Contact Coastal Care Services at: 855-481-0505 for* ***MMA only.*** ***Long-Term Care and Comprehensive*** *– Contact Molina Healthcare*
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover: - One initial evaluation per lifetime, completed by a team - Up to 3 screenings per year - Up to 3 follow-up evaluations per year - Up to 2 training or support sessions per week	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary.	No

Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover: - One adult health screening (check-up) per year - Child health check-ups are provided based on age and developmental needs - One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover: - Up to 26 hours per year	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: - Covered as medically necessary	No
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: - Covered as medically necessary	No
*Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover: - Up to 39 hours per year	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover: - Up to 4 visits per day for pregnant recipients and recipients ages 0-20 - Up to 3 visits per day for all other recipients	Yes – *Contact Coastal Care Services at: 855-481-0505 for* ***MMA only****.* ***Long-Term Care and Comprehensive*** *– Contact Molina Healthcare*

Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	- Covered as medically necessary - See information on Patient Responsibility for more information	No – *Effective 01/01/19*
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover: - Up to 26 hours per year	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation: - Up to 365/366 days for recipients ages 0-20 - Up to 45 days for all other recipients (extra days are covered for emergencies)	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	- Covered as medically necessary	No
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	- Covered as medically necessary	No
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization*
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	- Covered as medically necessary	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization*

Medication Management Services	Services to help people understand and make the best choices for taking medication	- Covered as medically necessary	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization*
*Mental Health Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*MultiSystemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	- Covered as medically necessary	No
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: - Out-of-state travel - Transfers between hospitals or facilities - Escorts when medically necessary	No
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term	- We cover 365/366 days of services in nursing facilities as medically necessary - See information on Patient Responsibility for more information	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap:	Yes – *Contact American Therapy Administrators*

	your daily life, like writing, feeding yourself, and using items around the house	- One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	*(HN1) at: 888-550-8800*
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	- Covered as medically necessary	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	- Covered as medically necessary	No
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	- Emergency services are covered as medically necessary - Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	- Covered as medically necessary. Some service limits may apply	No
*Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Physical Therapy Services	Physical therapy includes exercises , stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages:	Yes – *Contact American Therapy Administrators (HN1) at: 888-550-8800*

		- Follow-up wheelchair evaluations, one at delivery and one 6-months later	
Podiatry Services	Medical care and other treatments for the feet	We cover: - Up to 24 office visits per year - Foot and nail care - X-rays and other imaging for the foot, ankle and lower leg - Surgery on the foot, ankle or lower leg	No
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover: - Up to a 34-day supply of drugs, per prescription - Refills, as prescribed	No
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover: - Up to 24 hours per day	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover: - 10 hours of psychological testing per year	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover: - Up to 480 hours per year	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays	- Covered as medically necessary	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Reproductive Services	Services for women who are pregnant or	We cover family planning services. You can get these services and	No

	want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover: - Respiratory testing - Respiratory surgical procedures - Respiratory device management	Yes
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover: - One initial evaluation per year - One therapy re-evaluation per 6 months - Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders	We cover the following : - Assessments - Foster care services - Group home services	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following services for children ages 0-20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year We cover the following services for adults: - One communication evaluation per 5 years	Yes – *Contact American Therapy Administrators (HN1) at: 888-550-8800*
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
*****Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for*

	week, for people who are recovering from substance use disorders		*specific codes that require authorization.*
*****Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover: - Up to 9 hours per month	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following services when prescribed by your doctor: - Two pairs of eyeglasses for children ages 0-20 - Contact lenses - Prosthetic eyes	No
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	- Covered as medically necessary	No

Covered Services - Long-Term Care

The table below lists the long-term care services covered by our Plan. Remember, services must be medically necessary in order for us to pay for them.

If you have any questions about any of the covered long-term care services, please call Case Management or Provider Services.

Service	Description	Prior Authorization
Companion Care	This service helps you fix meals, do laundry and light housekeeping	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during meal times, you can eat there.	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Assistive Care Services	These are 24-hour services if you live in an adult family care home or an assisted living facility	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Behavioral Management	Services for mental health or substance abuse needs	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Caregiver Training	Training and counseling for the people who help take care of you	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*

	include major changes like new carpeting, roof repairs, plumbing systems, etc.	
Home Delivered Meals	This service delivers healthy meals to your home	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	No – *Effective 01/01/19*
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Medication Administration	Help taking medications if you can't take medication by yourself	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Medication Management	A review of all of the prescription and over-the-counter medications you are taking	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*

Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Home.	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow	Yes – *Refer to Molina's provider website or portal for specific codes that require authorization.*
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	No

Expanded Benefits

The table below lists the long-term care services covered by our Plan. Remember, services must be medically necessary in order for us to pay for them. Expanded benefits are extra goods or services we provide to you, free of charge. Call Member Services to ask about getting expanded benefits.

Benefit Category	Procedure Code	Procedure Code Description	Min Age	Max Age	Expanded Benefit Coverage (Units)	Prior Authorization Required	Co-payment Requirements
Acupuncture	97810	Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	21	No Max	Up to 4 units (15 minutes x 4 = 60 minutes) per visit - up to 24 visits / year	Yes	N/A
	97811	Each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles					
	97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient					
	97814	Each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles					
Chiropractic	98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	21	No Max	Current coverage: 1 new patient visit + 23 established patient visits or 24 estab.patient visits per year, plus X-rays. Change to 1 new + 35 estab. or 36 estab. (12	None	N/A
	98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions					
	98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions					

	98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions			additional visits per year) plus X-rays.		
CVS Discount Program	N/A	N/A	0	No Max	20% off discount on certain OTC items	No	No
Home Delivered Meals - Disaster Preparedness/Relief	S5170	Medical Nutrition Group	0	No Max	One (1) annually	Yes	No
Home Delivered Meals - Post-Facility Discharge (Hospital or Nursing Facility)	S5170	Medical Nutrition Group	0	No Max	Three (3) meals per day for thirty (30) days	Yes	No Copay
	S9977	Meals per diem; not otherwise specified					
Home Health Nursing/Aide Services	S9122	Home health aide or certified nurse assistant, providing care in the home; per hour.	21	No Max	Unlimited with prior authorization	Yes	No Copay
	S9123	Nursing care, in the home; by registered nurse, per hour					
	S9124	Nursing care, in the home; by a licensed practical nurse, per hour					
	T1019	Personal Care Ser Per 15 Min					
	T1020	Personal Care Services, Per Diem					
	T1021	Home Health Aide Or Certified Nursing Aide, Per Visit					
	T1030	Registered Nurse Home					

		Care, Per Diem					
	T1031	Licensed Practical Nurse, Home Care, Per Diem					
Housing Assistance	H0044	Supported Housing, per month	21	No Max	Up to $500 per lifetime	Yes	No Copay
Massage Therapy	97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	21	No Max	Up to 1 hour vest / week; up to 24 annually	Yes	N/A
	97140	Therapeutic Procedure, 15 minutes. Mobilization, manipulation, manual lymphatic drainage, manual traction, one or more regions.					
	97010	Hot and Cold pack Therapy (Hydro Therapy)					
	97112	Neuromuscular Therapy					
Meals - Non-emergency Transportation Day-Trips	A0190	Noner Transport Meals Recip	0	No Max	Provide one meal for day trip over 150 miles - up to $25 / person - maximum 2 people (member + 1 escort)	Yes	No copay
	A0210	Noner Transport Meals Escort					
Nutritional Counseling	S9452	Nutrition Class	21	No Max	Limit of five (5) visits per year	Yes	No Copay
	97802	Medical Nutrition Indiv In					
	97803	Med Nutrition Indiv Subseq					

	97804	Medical Nutrition Group					
	G0270	Mnt Subs Tx For Change Dx					
	G0271	Group Mnt 2 Or More 30 Mins					
Therapy - Art	G0176	Activity therapy, such as music, dance, art, or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	21	No Max	Unlimited therapy visits, training and/or supplies	Yes	No Copay
Therapy - Pet	G0176	Activity therapy, such as music, dance, art, or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	21	No Max	Unlimited	Yes	No Copay
Vaccine - Influenza	90630	Flu vacc iiv4 no preserv id	21	No max	One (1) vaccine per year; the plan will reimburse the enrollee for the cost of the vaccination and administration	No	No copay
	90653	Iiv adjuvant vaccine im					
	90654	Flu vacc iiv3 no preserv id					
	90655	Iiv3 vacc no prsv 0.25 ml im					
	90656	Iiv3 vacc no prsv 0.5 ml im					
	90657	Iiv3 vaccine splt 0.25 ml im					
	90658	Iiv3 vaccine splt 0.5 ml im					
	90660	Laiv3 vaccine intranasal					
	90661	Cciiv3 vac no prsv 0.5 ml im					

	90662	Iiv no prsv increased ag im					
	90664	Laiv vacc pandemic intranasl					
	90666	Flu vac pandem prsrv free im					
	90667	Flu Vacc Pandemic Adjuvant Im					
	90668	Iiv vaccine pandemic im					
	90672	Laiv4 vaccine intranasal					
	90673	Riv3 vaccine no preserv im					
	90682	Riv4 vacc recombinant dna im					
	90685	Iiv4 vacc no prsv 0.25 ml im					
	90686	Iiv4 vacc no prsv 0.5 ml im					
	90687	Iiv4 vaccine splt 0.25 ml im					
	90688	Iiv4 vaccine splt 0.5 ml im					
	Q2034	Influenza virus vaccine, split virus, for intramuscular use (agriflu)					
	Q2035	Afluria vacc, 3 yrs & >, im					
	Q2036	Flulaval Vacc, 3 Yrs & >, Im					
	Q2037	Fluvirin Vacc, 3 Yrs & >, Im					
	Q2038	Fluzone Vacc, 3 Yrs & >, Im					
	Q2039	Influenza virus vaccine, nos					
	G0008	Admin Influenza Vaccine					
Vaccine - Pneumonia (Pneumococcal)	90670	Pcv13 vaccine im	21	No Max	Unlimited with prior authorization	Yes	No Copay
	90732	Pneumococcal polysaccharide 23 valent subcutaneous or intramuscular					
	G0009	Admin Pneumococcal Vaccine					

Vaccine - TDaP	90715	Tetanus diphtheria toxoids acellular pertussis vaccine (TDaP) intramuscular	21	No Max	One (1) vaccine per pregnancy	Yes	No Copay
Vaccine - Shingles (Varicella- Zoster)	90736	Hzv vaccine live subq	21	No Max	One (1) vaccine per lifetime	None	No Copay
	90750	Hzv vacc recombinant im njx					
Waived Copayments	N/A	N/A	21	No Max	All services	No	No Copay

Molina Healthcare will notify affected providers when it makes changes in covered services, including its expanded benefits at least thirty (30) calendar days before the effective date of the change.

In addition to receiving health care services from providers who contract with Molina Healthcare, Members may self-refer and obtain services as listed below.

- Emergency services from any emergency care provider
- Family planning services from any participating Medicaid provider, regardless of whether the provider is a plan provider
- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as Tuberculosis and Human Immunodeficiency rendered by County Health Departments
- Immunizations by County Health Departments

Well Child Visits (formerly CHCUP)

Well Child visits are available to every Medicaid-eligible child under age (21). It includes a comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status); comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at age three or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate. A Well Child visit is a comprehensive, preventive health screening service. Well Child visits are performed according to a periodicity schedule that ensures that children have a health screening on a routine basis. In addition, a child may receive a Well Child visit whenever it is medically necessary or requested by the child or the child's parent or caregiver. If a child is diagnosed as having a medical problem, the child is treated for that problem through the applicable Medicaid program, such as physician, dental and therapy services.

To provide Well Child visits, a provider must be enrolled in Medicaid as a provider with a Category of Service (code 55) for Well Child Visit.

As licensed health care professionals you are aware that performing a blood test is a federal requirement at specific intervals during the Well Child visit. This note is to remind you how important it is to document the blood tests you are performing in compliance with this federal mandate. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received.

The Well Child schedule listed below is based on the American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care" and Florida Medicaid's recommendation to include the (7) and (9) year old recipients.

Nothing in this handbook waives the EPSDT requirements of 42 U.S.C. § 1396d(r)(5). As such, in accordance with § 1396d(r) and all binding federal precedents interpreting it, Molina must, for Medicaid

eligible children under the age of twenty-one (21), pay for any “other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” (42 U.S.C. 1396d(r)(5)) Molina evaluate the medical necessity of the services and will not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21).

The Well Child Visit schedule is:

- Birth;
- 3-5 days for newborns discharged in less than 48 hours after delivery;
- By (1) month;
- (2) months;
- (4) months;
- (6) months;
- (9) months;
- (12) months;
- (15) months;
- (18) months;
- (24) months;
- (30) months;
- Once every year for ages 3-20.

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age (4), then the next periodic screening is performed at age (5).

* Florida Medicaid recommends check-ups at (7) and (9) years of age for those children at risk.

The federal guidelines outlined below specify the minimum requirements included in each Well Child Care (WCC) exam for each of the following age groups; The Well Child Care (WCC) exam (0-18) months is scheduled on a monthly basis, once per year for (2-6) years, and at (7-20) years old. During the Well Child visit visit, providers are required to deliver the following:

Well Child Domain	Infants (0-18) months	Children (2-6) years	Adolescents (7-20) years
Physical Exam and Health History	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)

Development and Behavior Assessment	• Gross motor • Fine motor • Social/emotional • Nutritional (any one of these)	• Gross motor • Fine motor • Communication • Self-help skills • Cognitive skills • Social/emotional • Regular physical activity • Nutritional (any one of these)	• Social/emotional • Regular physical activity • Nutritional (any one of these)
Mental Health Assessment	Mental health (must be addressed)	Mental health (must be addressed)	• Mental health • Substance abuse (either one of these)
Health Education/ Anticipatory Guidance	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • STD prevention • Smoking/tobacco (any one of these)

Since 2003, Health and Recovery Services Administration (HRSA) has used Health Employer Data Information Set (HEDIS) Well-Child and Well-Adolescent measures to assess the health plans' rates for the number of children with qualifying Early Periodic Screening Diagnosis and Treatment Program EPSDT exams.

Providers must conduct these regular exams in order to meet the AHCA targeted state standard. When conducting a Well Child exam, please complete AHCA's Well Child Visit Tracking Form, ensure that the completed form is incorporated into the Member's medical record.

One of our goals at Molina Healthcare is to improve children's health, as measured by our Well Child rates. Your help with this effort is essential. If you have questions or suggestions related to Well Child Care regulations, please call our Health Education line at (855) 322-4076.

Vaccines for Children

The Centers for Disease Control and Prevention (CDC), which provides Vaccines for Children (VFC) funding, has developed strict accountability requirements from the state, local health jurisdictions, and individual providers. Molina Healthcare Providers should be enrolled in the VFC program through their local health department.

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

Molina Healthcare follows AHCA billing guidelines for reimbursing a provider's administration costs. We reimburse per Florida's fee schedule. Providers must bill state-supplied vaccines with the appropriate procedure codes.

Immunization Services

Immunization services provide vaccines to induce a state of being immune to or being protected from a disease. Medicaid reimburses these services for recipients from birth through 20 years of age. Molina Healthcare will reimburse simultaneous administration of all vaccines for which an enrollee under the age of twenty-one (21) years is eligible at the time of each visit.

Molina Healthcare will follow only contraindications established by the Advisory Committee on Immunization Practices (ACIP), unless:

- In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or
- The particular requirement is not in compliance with Florida law, including Florida law relating to religious or other exemptions.

Molina participating providers must have a sufficient supply of vaccines. Providers that are directly enrolled in the VFC program must maintain adequate vaccine supplies.

Eligible Recipients

Medicaid eligible recipients from birth through eighteen (18) years of age are eligible to receive free vaccines through the federal Vaccine for Children (VFC) Program. The provider is reimbursed only for the administration of the vaccine. The vaccine is free to the provider through the Vaccine for Children (VFC) program, Department of Health.

Title XXI MediKids enrollees do not qualify for the VFC program. Providers must bill Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants.

Medicaid eligible recipients nineteen (19) through twenty (20) years of age may receive vaccines through their health care provider. These vaccines are not free to the provider and are reimbursed by Molina Healthcare. Reimbursement includes the administration fee and the cost of the vaccine.

Upon request by DCF and receipt of the enrollee's written permission, PCPs are encouraged to provide immunization information about enrollees requesting temporary cash assistance from DCF. This information is necessary in order to document that the enrollee has met the immunization requirements for enrollees receiving temporary cash assistance.

Vaccines for Recipients Birth through (18) Years

For eligible recipients from birth through (18) years of age, vaccines and combination vaccines providing protection against the following diseases are available free to the VFC-enrolled provider through the VFC program:

- Diphtheria, Tetanus and Pertussis (DTaP)
- Haemophilus Influenzae Type b (HIB)
- Hepatitis B (pediatric and adult)
- Meningococcal Conjugate (MCV4)
- Pneumococcal (PCV 7)
- Polio (IPV)
- Measles, Mumps, and Rubella (MMR)
- Tetanus and Diphtheria (Td) (Adult)
- Influenza
- Varicella
- Human Papillomavirus (HPV)
- Rotavirus

The following vaccines are available by request or for high-risk areas only through the VFC program:

- Hepatitis A
- Diphtheria and Tetanus (DT) (Pediatric)
- Pneumococcal Polysaccharide (PPV)
- Meningococcal Polysaccharide (MPSV4)

Vaccines for Recipients (19) through (20) Years

For eligible recipients ages (19) through (20) years, vaccines and combination vaccines providing protection against the following diseases are reimbursable:

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, and Rubella (MMR)
- Meningococcal Conjugate (MCV 4)

- Meningococcal Polysaccharide (MPSV4)
- Pneumococcal Polysaccharide (PPV)
- Tetanus and Diphtheria (Td)
- Varicella

Vaccines for Recipients (21) Years and Older

Medicaid does not cover immunization services for recipients who are (21) years of age and older. However, Molina Healthcare covers the following:

- Influenza, once per year
- Pneumococcal, once per lifetime (subject to prior authorization)
- Herpes Zoster (Shingles), once per lifetime (subject to prior authorization)

Benefit must be accessed at a participating CVS Pharmacy.

Vaccines Excluded from VFC Program

Medicaid may reimburse the cost of the vaccine and an administration fee for all recipients 0-18 years of age who receive vaccines not covered by the VFC program.

Vaccine for Children Program (VFC)

Providers must enroll in the VFC program to receive free vaccines for 0-18 year olds through the VFC program. Information regarding the Vaccine for Children (VFC) Program is available by calling the State of Florida Department of Health, Bureau of Immunization, at 800-4-VFC-KID or 800-483-2543.

Administration Fee Reimbursement

Medicaid reimburses an administration fee to physicians, ARNPs and PAs providing free vaccines through the VFC Program to Medicaid eligible recipients from birth through (18) years of age.

Specialty Pharmaceuticals/Injectables and Infusion Services

Newly FDA approved drugs 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.

For Home Infusion services information, please contact Coastal Care Services at: (855) 481-0505.

Florida SHOTS

Molina Healthcare is enrolled as a data partner with Florida SHOTS (State Health Online Tracking System). All immunization data is submitted using the process and format specified by AHCA.

Vaccine Reimbursement

Medicaid reimbursement for providing vaccinations to Medicaid-eligible recipients (19-20) years of age includes the cost of the vaccine and an administration fee.

The provider must bill with the appropriate HCPCS procedure code assigned to the vaccine and a modifier HA when appropriate.

Well Child Visits

A Well Child screening is reimbursable in addition to reimbursement for immunizations.

Evaluation and Management Services

Evaluation and management (E&M) services are reimbursable in addition to the administration fee for vaccines, provided the visit is for a separate and identifiable service and the services are documented in the medical record.

Immunization Schedule

Providers should use the current Recommended Childhood Immunization Schedule that is developed and endorsed by the Advisory Committee on Immunization Practices, the Committee on Infectious Diseases of the American Academy of Pediatrics, and Infectious Diseases of the American Academy of Family Physicians. The most recent schedule is available on the Centers for Disease Control website at www.cdc.gov.

Procedure Codes and Fees

See the Physician Services Fee Schedule for the procedure codes and fees. The fee schedules are available on the Medicaid fiscal agent website at:

http://ahca.myflorida.com/medicaid/review/Promulgated.shtml

Urgent Care Services

Urgent care services are covered by Molina Healthcare without a referral.

(24) Hour Nurse Advice Line

Members may call (888) 275-8750 anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week, to assess symptoms and help make good health care decisions.

Molina Healthcare is committed to helping our Members:

- Prudently use the services of your office
- Understand how to handle routine health problems at home

- Avoid making non-emergent visits to the emergency room (ER)

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

Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. The goal of Molina is to provide our members high quality, cost effective drug therapy. Molina works with our providers and pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina Health Plans with managing pharmacy resources and to improve the overall satisfaction of Molina Health Plans' members and providers. It seeks to ensure Molina Health Plans' members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The Committee voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting www.MolinaHealthcare.com or calling Molina at (855) 322-4076

Drug Formulary

The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit www.MolinaHealthcare.com

Mediations will fall into the following categories. Information on procedures to obtain these medications is described within this document and also available on the website.

Formulary Medications

In some cases, patients may only be able to receive certain quantities of medication. Information on limits are included and can be found in the Formulary document.

Formulary medications with PA may require the use of first line medications before they are approved.

Quantity Limitations

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

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

Non-Formulary Medications

Non-Formulary medications may be considered for exception when Formulary medications are not appropriate for a particular patient or have proven ineffective. Requests for Formulary Exceptions should be submitted using a PA form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity.

Generic Substitution

Generic drugs should be dispensed whenever available. If the use of a particular brand name 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 (6) months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

Medications not covered by Medicaid are excluded from coverage. For example, drugs used in the treatment of fertility, weight loss, erectile dysfunction, or those used for cosmetic purposes are not part of the benefit.

Submitting a Prior Authorization Request

Molina will only process completed request forms, the following information MUST be included for the request form to be considered complete.

- Member First name, Last Name, Date of Birth and Identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

If information is missing the data entry team will first attempt to call your office to obtain the information, if unsuccessful a fax will be generated and sent requesting missing information.

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. Some medications, such as those listed with (SP) Specialty on the Preferred Formulary require clinical notes for review. If clinical information and/or medical justification is missing Molina will either fax or call your office to request clinical information be sent in to complete review. To avoid delays in

decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Pharmacy Prior Authorization/Exception Form to Molina at (866)236-8531. A blank Pharmacy Prior Authorization/Exception Form may be obtained by accessing www.MolinaHealthcare.com or by calling (855)-322-4076.

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 (NDCs) for billing and specialty pharmacy for dispensing to the patient or provider. Some of these same medications may be covered through the medical benefit using Healthcare Common Procedure Coding System (HCPC) J-codes via paper or electronic medical claim submission.

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

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

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 Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at www.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.

Telehealth and Telemedicine Services

You may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

(1) Telemedicine services provided under Florida Medicaid must be performed by licensed practitioners within their scope of practice;

(2) Telemedicine services must involve the use of interactive telecommunications equipment which includes, at a minimum, audio and video equipment permitting two-way, real time, communication between the enrollee and the practitioner; and

(3) Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

When providing services through telemedicine, the Managed Care Plan shall ensure:

(1) The telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable;

(2) The Managed Care Plan's providers using telemedicine comply with HIPAA and other state and federal laws pertaining to patient privacy;

(3) The Managed Care Plan's telemedicine policies and procedures comply with the requirements in this Contract; and

(4) Provider training regarding the telemedicine requirements in this Contract.

When telemedicine services are provided, the Managed Care Plan shall ensure that the enrollee's medical/case record includes documentation, as applicable. For more information, please review the ***Medical/Case Record Requirements*** section of this manual.

Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services. The enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter.

Fraud and Abuse Protocols

If you have been approved by Molina Healthcare to provide services through telemedicine, you are required to have protocols to prevent fraud and abuse. These protocols must address:

(a) Authentication and authorization of users;
(b) Authentication of the origin of the information;
(c) The prevention of unauthorized access to the system or information;
(d) System security, including the integrity of information that is collected, program integrity and system integrity; and
(e) Maintenance of documentation about system and information usage.

Health Education Programs - Healthy Behaviors

Molina will offer programs to our members who want to stop smoking, lose weight, or address any drug abuse problems. We will reward members who join and meet certain goals.

The programs include:

- Smoking Cessation Program
- Pediatric Preventive Care
- Weight Loss Programs
- Alcohol or Substance Abuse Program
- Pregnancy Rewards Pregnancy Program
- Adult Access to Preventive and Ambulatory Health Services

Disease Management Programs

Molina Healthcare wants providers to be aware of disease management programs offered to assist with care management. The programs that can help providers manage their patient's condition. These include programs, such as:

- Asthma
- Congestive Heart Failure
- COPD
- CVD
- Diabetes
- Heart Disease
- HIV/AIDS
- Hypertension

A Care Manager/Nurse is on hand to teach your Patient's about their disease (s). He/she will manage the care with their (PCP) and provide other resources. There are many ways a member can identify to

participate in these programs. These programs are not meant to replace or interfere with the member's physician assessment and care. Our goal is to partner with you in delivering quality healthcare to our members. Members have the option to opt out at any time.

For more info about our programs, please call the Member Services Department at:

(866) 472-4585
(English) TTY at 1-800-955-8771
(Spanish) TTY at 1-877-955-8773
or

Visit **www.molinahealthcare.com**

Pregnancy Health Management Program

We care about the health of our pregnant members and their babies. Molina's pregnancy program will make sure member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/member the support needed and answer questions you may have. You will be mailed a workbook and other resources are available to the member. The member will also learn ways to stay healthy after child birth. Special care is given to those who have a high-risk pregnancy. It is the member's choice to be in the program. They can choose to be removed from the program at any time. Molina Health Care is requesting your office to complete the pregnancy notification form (refer to www.molinahealthcare.com for form) and return to us as soon as pregnancy is confirmed. Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. The Pregnancy Rewards SM pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. The Pregnancy Rewards SM does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to members.

Pregnancy Rewards SM Program Activities

Pregnancy RewardsSM Pregnancy Health management Program encompasses clinical case management, member outreach and member and provider communication and education. The Prenatal Case Management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program activities include early identification of pregnant members, early screening for potential risk factors, provision of telephonic and written trimester appropriate education to all pregnant members and families, referral of high-risk members to prenatal case management, and provision of assessment information to physicians.

Additional Pregnancy Rewards SM Program Benefits:

- Prenatal and postpartum care manager follow-up with the patient to ensure that physician and discharge instructions are followed.
- Risk Assessment – An initial health assessment is performed telephonically or via a mailed prenatal screening survey to identify risk factors. Members are stratified to the appropriate level of care, 3 through 4:
    - Level 3 = Normal pregnancy with no identified risks
    - Level 2 = High risk pregnancy with risk factors including but not limited to; < age (18) or > (35), Parity > (5), multi-fetal gestation, inter-pregnancy interval of less than (4) to (6) months, BMI > (30), depression, hyperemesis, thyroid disorder, anemia.
    - Level 3 = High risk pregnancy with risk factors including but not limited to; Alcohol, tobacco or other substance use, past history of an eating disorder, asthma, poor nutrition per initial screening, incompetent cervix, placenta previa, IUGR, pre-eclampsia, hypertension, DVT
    - Level 4 = High risk pregnancy with risk factors including but not limited to; heart disease, lupus or scleroderma, diabetes, epilepsy, active cancer, ESRD, HIV/AIDS, sickle cell, active psychoses, domestic violence.
    - Participants identified with a nutritional risk will undergo a comprehensive nutrition assessment and a meal plan developed by a Registered Dietitian.
- Prenatal Case Management – Members assessed at level of care 3 – 4 are contacted via telephone for further intervention and education. A care plan is developed and shared with the physician to ensure that all educational and care needs are met. Prenatal case management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care referrals, coordination of home health care and DME service and referral to support groups or community social services. The case management data base generates reminders for call backs for specific assessments, prenatal visits, postpartum visits and well-baby checkups.
- Pregnancy newsletters – Educational newsletters are mailed to members each trimester throughout the pregnancy, including the postpartum period.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.
- Member Outreach – Pregnancy Rewards SM Program is promoted to members through various means including, program brochures in new member Welcome Packets, other member mailings, Member newsletters, Provider newsletters, posters and brochures placed in practitioner's offices and marketing materials and collaboration with national and local community-based entities.

Health Management Programs

Molina Healthcare's Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services.

Breathe with Ease

Molina Healthcare provides an asthma disease Management program called Breathe with Ease, designed to assist Members in understanding their disease. Molina Healthcare has a special interest in asthma, as it is the number one chronic diagnosis for our Members. This program was developed with the help of several community Providers with large asthma populations. The program educates the Member and family about asthma symptom identification and control. Our goal is to partner with you to strengthen asthma care in the community.

Breathe with Ease Program Activities

The first component of our program provides general asthma education to all identified asthma Members, including an asthma newsletter. Our goal is to provide Members with a basic understanding of asthma and related concepts, such as common triggers. We also encourage Members to see their PCP regularly for asthma status checks, and important preventive and well-child care.

The second component of our program offers Members identified as having high needs an opportunity to enroll in our more intensive asthma program. We identify these Members through claims and pharmacy data, with a specific focus on ER utilization and inpatient admissions for asthma. Members who choose to participate are sent an asthma kit. The kit currently contains an age-appropriate asthma workbook, video, spacer, magnet with (24) hour nurse advice line phone number, and an allergen-proof pillowcase. Molina Healthcare Members with moderate or severe persistent asthma will also receive a peak flow meter, peak flow diaries and an asthma action plan form to be completed with you in your office.

Additional Asthma Program Benefits:

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with asthma. A Registered Nurse (RN) Care Manager calls all patients hospitalized for complications related to asthma. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment is then faxed to the PCP's office.
- Clinical Practice Guidelines – Molina Healthcare adopted the NHLBI Asthma Guidelines.
- Asthma Registry – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma Members in the program.
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.
- Asthma Profiles – We send PCPs a report or profile of patients with asthma. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

Healthy Living with Diabetes

Molina Healthcare has a diabetes health management program called Healthy Living with Diabetes designed to assist Members in understanding diabetes and self-care. Molina Healthcare has a special interest in diabetes, as it is the number one chronic diagnosis for our Basic Health Members.

The Healthy Living with Diabetes program includes:

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with diabetes. An RN Care Manager calls all patients hospitalized for complications related to diabetes. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment is then faxed to the PCP's office.

- Clinical Practice Guidelines – Molina Healthcare adopted the American Diabetes Association guidelines for diabetic care.

- Diabetes Registry – Molina Healthcare established a diabetes registry. The registry uses available claims and pharmacy information to identify and track diabetic Members in the program.

- Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members.

- Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to Members with diabetes.

- Diabetes Education – Diabetes education is covered for all Molina Healthcare Members. We encourage Providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.

- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.

- Diabetes Profiles – We will send the PCP a report or profile of patients with diabetes. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare diabetic patients not included in the profile.

To find out more information about the disease management programs, please call Member Services Department at (866) 472-4585.

Transportation

Non-Emergency Transportation

Molina Healthcare provides Non-Emergency Transportation through Access2Care Transportation to assist its Members with keeping, and traveling to medical appointments.

To make a reservation for a transportation service, contact Access2Care's reservation line for Molina Healthcare Members at: (888) 298-4781.

If Member needs further assistance, they can also call (866) 472-4585 and a Member Services Representative will assist them with this request.

Provider Responsibilities

All Molina providers must, at a minimum:

- Provide all services in an ethical, legal, culturally competent manner, free of discrimination against members based on age, race, creed, color, religion, gender identity, national origin, sexual orientation, marital, physical, mental, or socio-economic status
- Participate in and cooperate with Quality Improvement, Utilization Review, and other similar programs established by Molina Healthcare of Florida
- Participate in and cooperate with Molina Healthcare of Florida's grievance procedures
- Never balance bill Molina Healthcare of Florida members
- Comply with all federal and state laws regarding confidentiality of member records
- Participate in and cooperate with Molina Healthcare of Florida's Quality Management program to ensure the delivery of quality care in the most cost effective manner
- Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services
- Immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, **(800) 96ABUSE**
- Maintain communication with appropriate agencies, such as local police, poison control, and social service agencies to ensure members receive quality care.
- Contact a Molina Healthcare case manager if a member exhibits a significant change, is admitted to a hospital or hospice program.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the State to ensure

Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance from a State Medicaid Program.

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711
On Line: https://MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

It is important for Providers to ensure Molina has accurate practice and business information. Accurate information allows us to better support and serve our Provider Network and Members.

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

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

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

Please visit our Provider Online Directory at: https://providersearch.MolinaHealthcare.com to validate and correct most of your information. A convenient Provider web form can be found on the POD and additionally on the Provider Portal at https://provider.MolinaHealthcare.com. Or notify your Provider Services Representative if your information needs to be updated or corrected.

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*** section of this Provider Manual.

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Providers are required to provide timely responses to such communications.

Molina Electronic Solutions Requirements

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

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

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Portal.

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

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Provider Portal

Electronic Claims Submission Requirement

Molina requires participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider including:

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

- Increases accuracy of data and efficient information delivery
- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal. See our Provider Portal Quick Reference Guide https://provider.MolinaHealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 51062, refer to our website www.MolinaHealthcare.com for additional information.

While both options are embraced by Molina, Providers submitting Claims via Molina's Provider Portal (available to all Providers at no cost) offer a number of Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Provider Portal Claims submitting benefits include:

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

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

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, the ability to have searchable ERAs, and to 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.

Below is the link to register with Change Healthcare ProviderNet to receive EFTs/ERAs. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or (877) 389-1160.

Provider Portal

Providers are requested to register for and utilize Molina's Provider Portal. The Provider Portal is an easy to use, online tool available to all of our Providers at **no cost**. The Provider Portal offers the following functionality:

- Verify and print member eligibility – As well as view benefits, covered services and Member Health record.
- Member Roster – View a list of assigned membership for PCP(s)
- Claims Functions
  - Professional and Institutional Claims (individual or multiple claims)
  - Receive notification of Claims status change
  - Correct Claims
  - Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - Export Claims reports
  - Create and Manage Claim Templates
  - Open Saved Claims
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
  - Receive notification of change in status of Authorization/Service Requests
  - Create Authorization/Service Request Templates
- View HEDIS® Scores and compare to national benchmarks
- Appeals
  - Create and submit a Claim Appeal
  - Add Appeal attachments to Appeal
  - Receive Email Confirmation

Third Party Billers can access and utilize all Claim Functions. Third Party Billers no longer have to phone in to get Claim updates and to make changes. All Claim functionalities are now available for Third Party Billers online at Molina's Provider Portal.

Balance Billing

Providers contracted with Molina cannot bill the Member for any Covered Services. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers may not charge Members fees for Covered Services.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be 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. A Provider must verify a recipient's eligibility each time the recipient presents to their office for services. Payment for services rendered is based on enrollment and benefit eligibility.

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

Member Cost Share

Providers should verify the Molina Member's Cost Share status prior to requiring the Molina Member to pay co-pay, co-insurance, 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).

Healthcare 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, and Medical Necessity review determination 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 Healthcare Services section of this Provider Manual.

In Office Laboratory Tests

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

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (https://providersearch.MolinaHealthcare.com). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient service centers, please reach out to the In-Network Laboratory Provider.

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 is 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 Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out of network Provider. A prior authorization will be required from Molina except in the case of Emergency Services (please refer to the Healthcare Services section of this Manual).

Referrals are *not* required for visits to providers with the following specialties - ***Obstetrics and Gynecology, Dermatology, Chiropractic, and Podiatry***. Members may access these specialties directly.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a prior authorization.

Treatment Alternatives and Communication with Members

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

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. Additional information regarding Molina's pharmacy program is available in the Pharmacy section of this Provider Manual.

Participation in Quality Programs

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

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

Additional information regarding Quality Programs is available in 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. Please refer to the ***Compliance*** section of this Provider Manual for additional information.

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 appeals, the Provider will participate by providing medical records or statement if needed. This includes the maintenance and retention of Member records for a period of not 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.

Please refer to the ***Complaints, Grievance and Appeals*** **Process** section of this Provider Manual for additional information regarding this program.

Participation in Credentialing

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

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

More information about Molina's Credentialing program is available in the Credentialing section of this Provider Manual.

Delegation

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

Laboratory Services

Participating providers should submit laboratory specimens to Quest Diagnostics, Molina's preferred in-network provider for laboratory services. This requirement ensures that laboratory services are provided by a credentialed laboratory in the most cost-effective manner and ensures that Molina has access to laboratory data needed to measure performance quality and outcomes related to HEDIS.

Additionally, Molina allows only certain laboratory tests needed for immediate diagnosis and treatment to be performed in the physician's office. Please refer to the ***In-Office Laboratory Tests*** section of this manual

for more information. All other medically necessary laboratory testing must be directed to an in-network laboratory by the ordering physician. Claims for laboratory tests performed in the physician office, but not included in “In Office Tests” list will be denied.

For the latest list of patient services centers (draw sites), please refer to Molina’s Provider Directory (www.providersearch.molinahealthcare.com).

Healthy Start Provider Requirements

Florida's Healthy Start Prenatal Risk Screening

Molina Healthcare providers must offer Florida's Healthy Start prenatal risk screening to each pregnant member as part of her first prenatal visit. When conducting the Prenatal Risk-Screening, Molina providers must:

- Use the Department of Health-approved Healthy Start (Prenatal) Risk Screening Instrument.
- Keep a copy of the completed screening instrument in the member's medical record and provide a copy to the member.
- Submit the Healthy Start (Prenatal) Risk Screening Instrument to the CHD in the county where the prenatal screen was completed within ten (10) business days of completion of the screening.

Florida's Healthy Start Infant (Postnatal) Risk Screening Instrument

Florida hospitals electronically file the Healthy Start (Postnatal) Risk Screening Instrument Certificate of Live Birth with the CHD in the county of birth within five (5) business days of the birth.

For birthing facilities not participating in the Department of Health electronic birth registration system, required birth information must be filed with the CHD within five (5) business days of the birth. The provider must keep a copy of the completed Healthy Start (Postnatal) Risk Screening Instrument in the member's medical record and mail a copy to the member.

Ineligible Members

Pregnant members or infants who do not score high enough to be eligible for Healthy Start case management may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

- If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score; or
- If the determination is made subsequent to risk screening, the provider may refer the member or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors

associated with high risk, such as Human Immunodeficiency Virus (HIV), Hepatitis B, substance abuse or domestic violence.

All infants, children under the age of five (5), and pregnant, breast-feeding and postpartum women will be referred to the local WIC office. Molina Healthcare providers must provide:

- A completed Florida WIC program medical referral form with the current height or length and weight (taken within sixty (60) days of the WIC appointment);
- Hemoglobin or hematocrit; and
- Any identified medical/nutritional problems.

Providers must coordinate with the local WIC office to provide the above referral data from the most recent Well Child visit. For every WIC referral form completed, the provider must give a copy of the form to the member and keep a copy in the member's medical record.

HIV Testing

Molina Healthcare providers must offer all women of childbearing age HIV counseling and HIV testing at the initial prenatal care visit and again at twenty-eight (28) and thirty-two (32) weeks. If the member declines an HIV test, providers must obtain a signed objection.

Providers must offer counseling to all pregnant members who are HIV positive and the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services.

Hepatitis B Testing

All pregnant members receiving prenatal care must be screened for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit. A second HBsAg test must be conducted between twenty-eight (28) and thirty-two (32) weeks of pregnancy for all members who tested negative at the first prenatal visit, and are considered high risk for Hepatitis B infection.

Any HBsAg-positive women shall be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.

Infants born to HBsAg-positive members shall receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable preferably within 12 hours of birth, and shall complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States. Infants born to HBsAg-positive members must be tested for HBsAg and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series for success or failure of the therapy. Any child age 24 months or less (<24) who tests positive for HBsAg must be reported to the local CHD within twenty-four (24) hours of the positive test results.

Infants born to members who are HBsAg-positive shall be reported to the local CHD and Healthy Start regardless of their Healthy Start screening score.

Molina Healthcare providers must report all prenatal or postpartum members who test HBsAg-positive to the Perinatal Hepatitis B Prevention Coordinator at the local CHD utilizing the Practitioner Disease Report Form (DH- 2136).

Reporting must include the following information:

- Name
- Date of birth
- Race/Ethnicity
- Address
- Infants
- Contacts
- Laboratory test(s) performed and date the sample was collected
- The due date or estimated date of confinement,
- Whether the member received prenatal care, and
- Immunization dates for infants and contacts

Prenatal Care

Molina Healthcare providers must include the following in all prenatal care:

- A pregnancy test and a nursing assessment with referrals to a physician, PA or ARNP for comprehensive evaluation;

- Referral to care coordination/case management according to the needs of the member;

- Any necessary referrals and follow-up;

- Schedule return prenatal visits at least every four (4) weeks until week thirty-two (32), every two (2) weeks until week thirty-six (36), and every week thereafter until delivery, unless the member's condition requires more frequent visits;

- Contact those members who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;

- Assist members in making delivery arrangements, if necessary;

- Refer pregnant members to appropriate maternity and family services, including notifying medical service payers of member status for further eligibility determination for the member and unborn infant; and

- Screening of all pregnant members for tobacco use and make certain that the providers make available to pregnant members smoking cessation counseling and appropriate treatment as needed.

Nutritional Assessment/Counseling

Providers must provide nutritional assessment and counseling to all pregnant members and ensure the following:

- The provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes;
- Offer a mid-level nutrition assessment;
- Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician; and
- Documentation of the nutrition care plan in the medical record by the person providing counseling.

Obstetrical Delivery

Molina Healthcare uses generally accepted and approved protocols for both low-risk and high-risk deliveries, including Healthy Start and prenatal screening. For high risk pregnancies, OB care during labor and delivery must include preparation for symptomatic evaluation and member progression through the final stages of labor and postpartum care.

Preterm delivery risk assessments must be documented in the member's medical record by week twenty-eight (28).

Newborn Care

Molina Healthcare providers must supply the highest level of care for newborns beginning immediately after birth. Such level of care must include, but not be limited to:

- Instilling of prophylactic eye medications into each eye of the newborn;
- When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
- Weighing and measuring of the newborn;
- Inspecting the newborn for abnormalities and/or complications;
- Administering one half (.5) milligram of vitamin K;
- APGAR scoring
- Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and

- Laboratory screenings to test for metabolic, hereditary and congenital disorders known to result in significant impairment of health or intellect, in accordance with s. 383.14, F.S.

These required laboratory tests shall be processed through the State Public Health Laboratory. Molina will reimburse for these screenings at the established Medicaid rate or specified contracted rate.

Postpartum Care

For postpartum members, Molina Healthcare providers must:

- Provide a postpartum examination for the member within six (6) weeks after delivery;
- Ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate; and
- Ensure that continuing care of the newborn is provided through the Well Child Care program component and documented in the child's medical record.

Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency 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 and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at www.MolinaHealthcare.com, from your local Provider Services Representative and by calling Molina Provider Services at (855)-322-4076.

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must

post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the State to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

Members can also email the complaint to civil.rights@MolinaHealthcare.com.

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: https://www.federalregister.gov/d/2016-11458

Cultural Competency

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

Provider and Community Training

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

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

1. Written materials;
2. On-site cultural competency training;
3. Online cultural competency Provider training; and,
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, aids, and services that are congruent with cultural norms. Molina supports Members with disabilities, and assists Members with Limited English Proficiency.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction. Online materials found on www.MolinaHealthcare.com and

information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within plan's membership and
  - 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 Needs Assessment).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS and CAHPS results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2020.

24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (855)-322-4076. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

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

Documentation

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

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

Members who are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center, Quality, Healthcare Services and all other health plan functions.

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

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

Nurse Advice Line

Molina provides twenty-four (24) hours/seven (7) days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina's Nurse Advice Line directly (English line (888) 275-8750) or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Provider Notifications

Providers will immediately notify Molina Healthcare of Florida, if any of the following events occur:

- Provider's business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina Healthcare of Florida Community Plus member, or any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim
- Provider is the subject of any criminal investigation or proceeding
- Provider is convicted for crimes involving moral turpitude or felonies
- Provider is named in any civil claim that may jeopardize Provider's financial soundness

- There is a change in provider's business address, telephone number, ownership, or Tax Identification Number
- Provider's professional or general liability insurance is reduced or canceled
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours
- Any material change or addition to the information submitted as part of provider's application for participation with Molina Healthcare of Florida Community Plus
- Any other act, event or occurrence which materially affects provider's ability to carry out its duties under the Provider Services Agreement

PCP Responsibilities

- Coordinate and supervise the delivery and transition of care to for each assigned Member.
- Ensure newly enrolled Members receive an initial health assessment no later than one-hundred eighty (180) days following the date of enrollment and assignment to the PCP.
- Ensure 24/7/365 availability for members requiring emergency services.
- Ensure appointment access for all Members in accordance with the Access to Care Standards
- Provide Well Child Visits in accordance with the periodicity schedule referenced in the Well Child Visits section of this handbook.
- Provide immunizations in accordance with the Recommended Childhood Immunization
- Schedule for the US, or when necessary for the Member's health.
- Participate in the Vaccines for Children Program (VFC) for Members 18 years old and younger.
- Provide immunization information to the Department of Children and Families (DCF) upon request by DCF and receipt of the Member's written permission, for members requesting temporary cash assistance.
- Provide adult preventive care screenings in accordance with the U.S. Preventive Services Task Force guidelines
- Utilize Molina Healthcare network providers whenever possible. If services necessary are not available in network, contact Utilization Management for assistance.
- Maintain a procedure for contacting non-compliant Members.
- Ensure Members are aware of the availability of non-emergency transportation and assist members with transportation scheduling.
- Ensure Members are aware of the availability of free, oral interpretation and translation services, including Members requiring services for the hearing impaired.
- Provide a physical screening within seventy-two (72) hours, or immediately if required, for children taken into protective custody, emergency shelter, or foster care program by DCF.
- Submit timely, complete and accurate encounters for each visit where the PCP sees the Member.
- Submit encounters on a CMS-1500 form.

- Allow access to Molina Healthcare or its designee to inspect office, records, and/or operations when requested.
- Cooperate in investigations, reviews or audits conducted by Molina Healthcare, AHCA, or any other state or federal agency.

Site and Medical Record-Keeping Practice Reviews

Molina Healthcare has a process to ensure the offices of all PCPs, OB/Gyns and high volume behavioral health Providers meets Molina Healthcare office-site standards. Molina Healthcare assesses the quality, safety and accessibility of office sites where care is given. Standards and thresholds for office site criteria, medical treatment and record-keeping practices have been approved by Molina Healthcare's Professional Review Committee (PRC). The site and medical record-keeping review is conducted prior to the initial credentialing decision. The PRC considers site and medical record-keeping review reports with other criteria and information about the Provider when making initial credentialing/re-credentialing determinations.

New Providers joining a contracted medical group reviewed and found to be 80% or more in compliance with Molina Healthcare site review guidelines will not require another site review. A copy of the medical group's site and medical record-keeping practices review report will be filed in the Provider's credentials file and reviewed by the PRC as part of the initial credentialing process.

A standard site-visit survey form is completed at the time of each visit. This form includes the Site and Medical Record Keeping Practice Guidelines outlined below and the thresholds (3 or more complaints) for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting-room and examining-room space
- Availability of appointments
- Adequacy of medical/treatment record keeping
- Respond to complaints

Adequacy of Medical Record-Keeping Practices

During the site visit, Molina Healthcare discusses office documentation practices with the Provider or Provider's staff. This discussion includes a review of the forms and a method used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records.

Molina Healthcare assesses medical/treatment records for orderliness of record and documentation practices. To ensure Member confidentiality, Molina Healthcare reviews a blinded medical/treatment record or a model record instead of an actual record.

Improvement Plans/Corrective Action Plans

Within (30) calendar days of the review, a copy of the site review report and a letter will be sent to the medical group notifying them of their results. If the medical group does not achieve the required compliance with the site review standards, the Site Review Nurse (SRN) will do all of the following:

1. Send a letter to the Provider that identifies the compliance issues.
2. Send the Provider helpful information such as forms on which to document problems or medication allergies in the medical record.
3. Request the provider to submit a written corrective action plan to Molina within (30) calendar days.
4. Send notification that another review will be conducted of the office in six months.

When compliance is not achieved, the provider will be required to submit a written Corrective Action Plan (CAP) to Molina Healthcare within (30) calendar days of notification by Molina Healthcare. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or provider and must include the expected time frame for completion of activities. The SRN conducts additional site reviews of the office at six-month intervals until compliance is achieved. The information and any response made by the provider is included in the providers permanent credentials file and reported to the PRC on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.

Providers who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with Molina Healthcare's policy.

Relocations and Additional Sites

Providers should notify Molina Healthcare (60) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office will be conducted before the Provider's re-credentialing date.

Compliance Standards

Providers must demonstrate an overall 80% compliance with the medical record documentation guidelines listed below. A standard medical record review survey form is completed at the time of each visit. This form includes the Medical Record Documentation Guidelines outlined below and the thresholds for acceptable performance of these criteria. At least 5 to10 records per site is a generally- accepted target, though additional reviews must be completed for large group practices or when additional data is necessary in specific instances. Medical records are evaluated for the following:

- Medical record content includes: problem list, allergies, history, diagnosis, and treatment plan based on diagnosis
- Medical record organization
- Information filed in medical records
- Ease of retrieving medical records

- Confidential patient information

Site and Medical Record-Keeping Practice Guidelines

Facility

- Molina Healthcare conducts medical record review at all PCP sites that serve (10) or more members
- Each practice site may be reviewed during each (2) year period or will be reviewed at least (1) time every (3) year period
- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped 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 physician.

Safety

- 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 Cardio Pulmonary Resuscitation (CPR) certified employee is available.
- Yearly Occupational Safety and Health Administration (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 hazardous waste management.

Administration & Confidentiality

- 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 Clinical Laboratory Improvement Amendments waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectable and emergency medication is checked monthly for outdates.

- Drug refrigerator temperatures are documented daily.

Medical Record-Keeping Practices

- Each patient has a separate medical record. Records are stored away from patient areas and preferably locked. Records are available at each patient visit. Archived records are available within (24) hours.
- Pages are securely attached in the medical record. Computer users have individual passwords.
- Medical records are organized by dividers or color-coding when the thickness of the record dictates.
- A chronic problem list is included in the record for all adults and children.
- Allergies (and the lack of allergies) are prominently displayed at the front of the record.
- A complete health history questionnaire or History & Physical is part of the record.
- Health Maintenance forms includes dates of preventive services.
- A medication sheet is included for chronic medications.
- Advance Directives discussions are documented for those (18) years and older.
- Record-keeping is monitored for Quality Improvement and Health Insurance Portability and Accountability Act (HIPAA) compliance.

Medical Record Documentation

Molina Healthcare requires medical records be maintained in a manner that is current, detailed, organized and permits effective, confidential patient care and quality review. Molina Healthcare has a process to assess and improve, as needed, the quality of medical record-keeping.

At the time of re-credentialing, Molina Healthcare conducts a medical record review of PCPs. Guidelines have been reviewed and approved by the PRC. The PRC considers medical record review reports with other criteria and information about the Provider when making credentialing determinations.

Medical Records are reviewed to assure the following is reflected:

- All services are provided directly by a Provider
- All ancillary services and diagnostic studies are ordered by a Provider
- All diagnostic and therapeutic services for which a Member was referred by a Provider, such as:
    - Home health nursing reports
    - Specialty physician reports
    - Hospital discharge reports
    - Physical therapy reports

Telemedicine/Telehealth Providers

All records shall contain documentation to include the following items for services provided through telemedicine:

(1) A brief explanation of the use of telemedicine in each progress note;

(2) Documentation of telemedicine equipment used for the particular covered services provided; and

(3) A signed statement from the enrollee or the enrollee's authorized representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.

Medical Record Retention

Medical records must be maintained for a period not less than ten (10) years from the close of the Provider Services Agreement, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Molina Healthcare if the Provider Services Agreement is continuous.

Confidentiality of Medical Records

Molina Healthcare Members have the right to full consideration of privacy concerning their medical care. Members are also entitled to confidential treatment of all communications and records. Case discussion, consultations, examinations, and treatments are confidential and should be conducted with discretion. Written authorization from the Member or authorized legal representative must be obtained before medical records are released to anyone not directly connected with the care, except as permitted or required by law.

Confidential Information is defined as any form of data, including but not limited to, data that can directly or indirectly identify individual Members by character, conduct, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Conversations, whether in a formal or informal setting, e-mail, faxes and letters are also potential sources of confidential information.

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any confidential information to unauthorized persons. The office staff must receive periodic training in confidentiality of member information. This office procedure and training should include the following:

- Written authorization must be obtained from the Member or legal representative before medical records are made available to anyone not directly connected with the care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
- Only the portion of the medical record specified in the authorization should be made available to the requester and should be separated from the remainder of the Member's medical record.

Site Review Nurse (SRN)

A registered nurse with training and experience in quality improvement and ambulatory care evaluates the Provider's medical records using Molina Healthcare approved guidelines and audit tools.

Medical Record Standards

The Provider is responsible for maintaining an electronic or paper medical record for each individual member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and state regulations. The Provider must ensure his/her staff receives periodic training regarding the confidentiality of member information.

The Provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the member was referred to the Provider.

At a minimum, each medical record must be legible and maintained in detail with the following documentation:

- Identifying information of the member including name, Member identification number, date of birth, sex and legal guardianship (if applicable)
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications (or notation that none are known)
- Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Document referral services in enrollees' medical/case records
- Dated and signed entries by the appropriate party
- The chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider including behavioral health conditions
- Studies ordered (e.g., laboratory, x-ray, EKG) and referral reports

- Indicated therapies administered and prescribed including dosages and dates of initial or refill prescriptions
- Name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider
- Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services
- An immunization history
- Information relating to the Member's use of tobacco products and alcohol/substance abuse
- Summaries of all Emergency Services and Care and Hospital discharges with appropriate medically indicated follow up
- Reflection of the primary language spoken by the member and any translation needs of the member
- Identification of member's need for communication assistance in the delivery of health care services
- Copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13).
- Documentation that the Member was provided with written information concerning the member's right regarding Advance Directives (end of life wishes DNR(do not resuscitate), written instructions for wills, living wills or advance directives and health care powers of attorney) and whether or not the member has executed an Advance Directive. Neither Molina Healthcare nor any of its Providers shall, as a condition of treatment, require the member execute or waive an Advance Directive.
- A release document for each Member authorizing Molina Healthcare to release medical information for facilitation of medical care

Newborn Notification Process

Physicians must notify Molina Healthcare immediately after the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services.

The PCP or Specialist shall submit the Pregnancy Notification Report Form to Molina Healthcare immediately after the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services. Providers shall enter all applicable information on the form. The form should be submitted to Molina Healthcare's Pregnancy Rewards Fax Line (866) 440-9791, or via email to MFLBaby@MolinaHealthcare.com.

Abuse, Neglect, and Exploitation

All Molina Healthcare direct service providers must complete Abuse, Neglect, and Exploitation Training. This training may be provided by the Department of Children and Families, the local area agency on aging, the Department of Elder Affairs, or through licensing requirements.

Department of Children and Families
1317 Winewood Blvd
Bldg 1 – Room 202
Tallahassee, FL 32399-0700

Phone: (850)-487-1111
Fax: (850)-922-2993

"**Abuse**" means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee's physical, mental, or emotional health. Abuse includes acts and omissions.

"**Exploitation**" of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property for the benefit of someone other than the vulnerable adult.

2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

"**Neglect**" of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

"Neglect" of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

More information on Abuse, Neglect or Exploitation can be found on the Department of Children & Families website at: http://www.myflfamilies.com/service-programs/abuse-hotline/report-online

Reporting of Abuse, Neglect or Exploitation Including Critical and Adverse Incidents

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, **(800) 96ABUSE.** Additionally, all providers, including HCBS providers, must report adverse incidents including events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents to Molina Healthcare immediately.

For HCBS providers, Critical Incidents must be reported no more than twenty-four (24) hours of the incident. For MMA providers, Adverse Incidents must be reported no more than forty-eight (48) hours of the incident.

Documentation related to the suspected abuse, neglect, or exploitation, including the reporting of such, must be kept in a confidential file, separate from the enrollee record. Providers must make the file available to Molina Healthcare or any other State or Federal Agency upon request.

The Critical Incident Form is located on Molina Healthcare's website at:

http://www.molinahealthcare.com/providers/fl/PDF/Medicaid/forms_FL_CriticalIncidentReportingForm.pdf

To report a critical incident, provider should email the Critical Incident Form to:

MFLQIAlerts@MolinaHealthCare.Com

Critical/Adverse Incident Reporting Exceptions for MMA

Molina Healthcare does not require Critical Incident reporting from the following providers:

- Health Maintenance Organizations and Health Care Clinics reporting in accordance with s. 641.55, F.S.;
- Ambulatory Surgical Centers and Hospitals reporting in accordance with s. 395.0197, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.;
- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Crisis Stabilization Units, Residential Treatment Centers for children and adolescents, and Residential Treatment Facilities reporting in accordance with s. 394.459, F.S.,

Critical Incidents occurring in these licensed settings shall be reported in accordance with the facility's licensure requirements.

Critical/Adverse Incident Reporting Exceptions for LTC

Molina Healthcare does not require Critical Incident reporting from the following HCBS Providers:

- Nursing Facilities reporting in accordance with s. 400.147, F.S.;
- Assisted Living Facilities reporting in accordance with s. 429.23, F.S.

Critical incidents occurring in nursing facilities and ALFs will be addressed in accordance with Florida law.

Identifying Victims of Human Trafficking

For specific information regarding indications of Human Trafficking, please refer to the Florida Department of Children and Families at:

http://www.dcf.state.fl.us/programs/humantrafficking/docs/InformationKit.pdf

Provider Support

Molina Healthcare of Florida recognizes the importance of communication with its network providers, and offers various tools and resources to ensure access to the most-up-to date Molina Healthcare of Florida information. Providers may visit our website for member eligibility, claims status, or to download handbooks and forms. Hard copies of the handbook are available to all providers, at no charge. Contact Provider Services for a copy.

Providers may also call Provider Services and speak with a representative who will address any questions or concerns:

Provider Services Toll-Free Line: (855) 322-4076

On the web: www.molinahealthcare.com

Member Information and Marketing

Any written informational and marketing materials directed at Molina Healthcare Members must be developed at the fourth grade reading level and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials.

Contracted Providers *may not*:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the Managed Care Plan.
- Offer anything of value to induce recipients/enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in a Managed Care Plan.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

- Distribute marketing materials in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).
- Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

Contracted Providers ***may***:

- Provide the names of the Managed Care Plans with which they participate.
- Make available and/or distribute Managed Care Plan marketing materials outside of an exam room.
- Providers are permitted to make available and/or distribute Managed Care Plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates.
- Providers may distribute printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract. However, the Managed Care Plan shall ensure that:
    i. Materials do not "rank order" or highlight specific Managed Care Plans and include only objective information.
    ii. Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.
    iii. The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.

    Providers are also permitted to display posters or other materials in common areas such as the provider's waiting room.

    If a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates.
- Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.
- To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
- Share information with patients from the Agency's website or CMS' website.

- Announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).
- Make new affiliation announcements within the first thirty (30) calendar days of the new provider agreement.
- Make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.

Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.

Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.

Medical Management

Molina Healthcare Providers must ensure Members receive medically necessary health care services in a timely manner without undue interruption. The Member's PCP is responsible for:

- Providing routine medical care to Molina Healthcare Members
- Following up on missed appointments
- Prescribing diagnostic and/or laboratory tests and procedures
- Coordinating Referrals and obtaining Prior Authorization when required

This section on Referrals, Authorizations, and Utilization Management (UM) describes procedures that apply to directly contracted Molina Healthcare providers. All contracted providers must obtain Molina Healthcare's Authorization for specific services that require prior approval.

Utilization Management – Prior Authorization Process

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to, MCG (formerly known as Milliman Care Guidelines), Interqual®, other third-party guidelines, CMS guidelines, state guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively.

Referral versus Prior Authorization

Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a Specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the Specialist.

Specialists may refer Members to other Specialists or for ancillary services. Referrals and authorizations do not have to be routed back through the PCP.

Generally, prior authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, ensure participating Providers are utilized and all services are provided at the appropriate level of care for the Member's needs.

Molina Healthcare's Prior Authorization guidelines and Service Request Form are available on our website at:

http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

A hard copy of the Prior Authorization Guide and Service Request Form are furnished to all participating providers upon credentialing and when revised, or upon request from a provider.

Providers should send requests for prior authorizations to the Utilization Management Department by phone or fax based on the urgency of the requested service. Contact information is listed below.

Molina Healthcare Utilization Management Department
Phone: (855) 322-4076
Fax: (866) 440-9791

Providers are encouraged to use the Molina Healthcare Service Request Form. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)
- Provider demographic information (referring Provider and referred Specialist)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (Diagnosis Code and description)
- Clinical indications necessitating service or Referral
- Pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inpatient requests)

Providers may also submit authorization requests through Molina Healthcare's Web Portal at: www.molinahealthcare.com.

Pertinent data and information is required by the HCS staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the authorization. Authorization is based on verification of Member eligibility and benefit coverage at the time of service. Claims payment is contingent on eligibility for date of service and appropriate coding and limitations.

Molina Healthcare will process any non-urgent requests within fourteen (14) working days after receiving adequate clinical information. Urgent requests will be processed within (72) hours. If a Referral has been previously approved, the Specialist or vendor may call Molina Healthcare directly to request an extension of services. Information generally required to support the decision-making process includes:

- Adequate patient history related to the requested services
- Physical examination that addresses the area of the request
- Supporting lab and/or X-ray results to support the request
- Relevant PCP and/or Specialist progress notes or consultations
- Any other relevant information or data specific to the request

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (855) 322-4076.

Referrals to In-Network Specialists

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 Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Healthcare MMA. In the case of Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and Emergency Services. 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.

Referrals are *not* required for visits to providers with the following specialties - ***Obstetrics and Gynecology, Dermatology, Chiropractic, and Podiatry***. Members may access these specialties directly.

The electronic forms will be available on the web portal for our providers. Referral details will also be available for our members on the My Molina member portal and Health in Hand app.

Wrong Site Surgery

If it is determined a wrong site surgery was performed, Molina Healthcare will not reimburse the Providers responsible for the error. Molina Healthcare will immediately report these types of events that are identified as Critical Incidents to AHCA in addition to reporting a summary on a quarterly basis.

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 Healthcare does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage HCS decision makers to make determinations that result in under-utilization.

Also, we require our delegated medical groups/IPAs and subcontractors to avoid this kind of conflict of interest.

Coordination of Care

Molina Healthcare's Utilization Management, Case Management and Disease Management will work with providers, members, and member representatives to coordinate care, provide referral assistance and other support for members with chronic, complex, high- risk and catastrophic conditions. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

Molina Healthcare staff assists providers by identifying needs and issues that may not be verbalized by providers, assisting to identify resources 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 Healthcare staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

Continuity of Care

Molina Healthcare Members involved in an active course of treatment have the option to complete treatment with the Provider who initiated care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina Healthcare and a Provider will not interfere with this option.

Molina Healthcare will notify Members in active care at least 60 days before the termination date of the provider and allow Members to continue receiving services from the terminated provider for a minimum of 60 days after the termination date. Continuation of care may not exceed six (6) months after the termination date of the provider.

Molina shall continue the entire course of treatment with the recipient's current provider for the following services which may extend beyond sixty (60) days continuity of care period:

- Prenatal and postpartum care
- Transplant services
- Oncology (Radiation and/or Chemotherapy services from the current round of treatment)

- Full course of therapy Hepatitis C treatment drugs

Pregnant Members who have initiated a course of prenatal care may continue to receive care from a terminated provider through the completion of pregnancy and postpartum period, regardless of the trimester in which care was initiated.

Requests for continued care should be submitted to the Utilization Management Department at:

Phone: (855) 322-4076
Fax: (866) 440-9791

Continuity of Care may not apply if a provider is terminated for cause.

Continuity and Coordination of Provider Communication

Molina Healthcare 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.

24-Hour Telephonic Coverage

The network providers listed below are required to have 24-hour telephonic coverage:

- Assisted Living Facilities
- Emergency Response Systems
- Nursing Homes

Case Management

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

The Molina Healthcare case managers are licensed Registered Nurses (RNs) and are educated, trained and experienced in the case management process. 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 approval from the Member's PCP. The Molina Healthcare case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare case manager is responsible for assessing the Member's appropriateness

for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management

Members with high-risk medical conditions may be referred by their PCP or specialty care provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, specialty providers, ancillary providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the Member being referred.

Members with the following conditions may qualify for case management and should be referred to the Molina Healthcare CM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately
- Children with Special Health Care Needs

Referrals to the Case Management program may be made by contacting Molina Healthcare at:

Phone: (855) 322-4076

Fax: (866) 440-9791

PCP Responsibilities in Case Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with reports, updates, and information regarding the Member's progress through the case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Case Manager Role and Responsibilities

The case manager collaborates with all resources involved and the Member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, Providers, and the Member are responsible for implementing the plan of care. Additionally the case manager shall:

- Develop individual plans of care that address identified problems, needs and conditions
- Coordinate the delivery of covered services

- Issue authorizations for covered services
- Coordinate and integrate acute and long term care services
- Collaborate with member's physicians and other providers to arrange for needed care
- Provide frequent communication with members to evaluate and discuss needed care
- Promote independent living and quality of life
- Monitor and communicate the progress of the implemented plan of care to all involved resources
- Serve as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Coordinate appropriate education and encourage the Member's role in self-help
- Monitor progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program

Case managers will routinely assess member needs and perform interventions as necessary. Interventions may be performed by:

- Face-to face home visits with member and family/caregiver(s)
- Telephonic follow up with member and family/caregiver(s)
- Providing educational materials
- Communicating with service providers

Case managers are responsible for determining the appropriateness of all requests for authorization and changes to existing authorizations. Authorizations for new or changed services are initiated when one of the following conditions apply:

- Services are necessary to address health and social service needs of the member
- Member fails to respond to current care plan
- Services are furnished in a manner not primarily intended for the convenience of the member or member's caregiver(s)

Obtaining Authorization

All covered services must be authorized by Molina Healthcare of Florida Case Managers. Providers should contact the member's case manager for authorization of services, or submit a Prior Authorization Request Form via fax. The approval of services and scope of such services will be communicated in writing to the requesting provider.

Phone: (855) 322-4076

Fax: (877) 902-6825

Services that are covered by Medicare should be accessed through the Medicare Fee-For-Service program or through the member's Medicare Advantage plan.

Health Education and Disease Management Programs

Molina Healthcare's Health Education and Disease Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation and wellness.

Emergency Services

*Please refer to section **Hospitals** for additional information on Emergency Services.*

Molina Healthcare provides Utilization Management during business hours and a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, 911 information is given to all Members at the onset of any call to the Plan.

Medical Necessity Standards

"Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

Molina has processes for authorization of any medically necessary service to enrollees under the age of twenty-one (21), in accordance with Section 1905(a) of the Social Security Act, when:

(1) The service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook (as found on the AHCA website), Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or
(2) Is not a covered service of the plan; or
(3) The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Such services should be requested using the standard processes and should include any and all medical necessity support documentation.

Quality Improvement

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

Quality Improvement Program Goals

- Design and maintain programs that improve the care and service outcomes within identified Member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, Member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to Members.
- Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process, and outcomes.
- Using feedback from stakeholders, improve reporting methods to make information available, relevant and timely.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals, improve organizational communication and ensure participation of contracted community providers in clinical aspects of programs and services.
- Facilitate organizational efforts to achieve and maintain regulatory compliance and to continually review practices to ensure compliance with standards and contractual requirements.
- Identify and track adverse or critical incidents and review and analyze adverse or critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues.

The QIP assists in achieving these goals through an evaluation process of both clinical and service outcomes measuring the effectiveness of internal processes and active improvement interventions. The QIP outlines several functional aspects of the QIP that contributes to a high level of clinical and service quality.

- Health Management Programs; Breathe with Ease for Asthma, Healthy Living with Diabetes, Pregnancy Rewards high risk pregnancy program
- Preventive Care and Clinical Practice Guidelines
- Measurement of Clinical and Service Quality; HEDIS, CAHPS® (Consumer Assessment of Health plan Survey), Provider Satisfaction Survey, and Key Quality Metrics

Preventive Care and Clinical Practice Guidelines

This section provides an overview of adopted clinical practice guidelines for Molina Healthcare. All clinical practice guidelines are based on scientific evidence, review of medical literature, or appropriate established authority as cited. All recommendations are based on published consensus guidelines and do not favor any treatment based solely on cost consideration.

The recommendations for care are suggested as guidelines for making clinical decisions. Providers and their patients must work together to develop individual treatment plans tailored to the specific needs and circumstances of each patient.

Molina Healthcare has standard clinical practice guidelines in the following areas:

- Depression – Adopted from the American Psychiatric Association
- ADHD – Adopted from the American Psychiatric Association
- Asthma – Adopted from the new NHLBI Asthma Guidelines by the Florida State Medical Association, in conjunction with community asthma provider
- Cardiovascular – ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in Adults, ATPIII Guidelines for High Blood Cholesterol, Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) and the AHA/ACC Guidelines for Preventing Heart Attack and Death in Patients With Atherosclerotic Cardiovascular Disease: 2001 Update
- COPD – The Global Initiative for Chronic Obstructive Lung Disease guidelines for COPD care
- Diabetes Mellitus – Adopted from the American Diabetes Association Clinical Practice Guidelines
- Preventive Care and Pregnancy Guidelines – Based on recommendations from the U.S. Preventive Services Task Force

On the Molina Healthcare website you will also find information regarding:

- Preventive Screening, Immunization and Counseling Guidelines
- Pregnancy Guidelines
- Well Child Forms (formerly known as CHCUP)
- Immunization Schedules
- Educational tools for patients
- Educational tools for your office

Guidelines are reviewed annually and updated as appropriate. If you would like a printed copy of the guidelines, you may request it by calling our **Health Education Line** at **(855) 322-4076.**

Timely Access Standards:

Appointments for **urgent** medical or behavioral health care services shall be provided:

- Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.
- Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization.

Appointments for **non-urgent** care services shall be provided:

- Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
- Within fourteen (14) days for initial outpatient behavioral health treatment.
- Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
- Within thirty (30) days of a request for a primary care appointment.
- Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

Measurement of Clinical and Service Quality:

- Health Employer Data Information Set (HEDIS)
- Consumer Assessment of Health Plans Survey (CAHPS®)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

HEDIS

Molina Healthcare utilizes NCQA HEDIS as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS is conducted annually 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, appropriate use of asthma medications, and prenatal and postpartum care.

HEDIS results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare's clinical quality improvement 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. These activities include Molina Healthcare's diabetic and asthma health management programs, childhood and adolescent well-child and immunization program, and prenatal and postpartum care programs.

Selected HEDIS results are provided to (HRSA) as part of our contract Health plans also submits results directly to NCQA, consistent with the original intent of HEDIS – to provide health care purchasers data with which to make informed decisions. The data is also used by NCQA to establish health plan performance benchmarks and are an integral part of the NCQA health plan accreditation process.

Your office may be requested to submit documentation from medical files as part of the HEDIS data collection process.

CAHPS®

CAHPS® is the tool used by NCQA to summarize Member satisfaction with health care, including Providers and health plans. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Providers Communicate, Courteous and Helpful Office Staff, and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected adult Members. In even-numbered years, HRSA also sponsors a Medicaid CAHPS® survey specific to the care provided to pediatric Members.

CAHPS® survey 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 Healthcare's quality improvement activities and are used by external agencies and health care purchasers to help ascertain the quality of services being delivered.

Provider Satisfaction Survey

Recognizing that HEDIS and CAHPS® both focus on Member experience with health care Providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey in the fall of each year. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods we use to identify improvement areas pertaining to the Provider network. The survey results have helped establish improvement activities relating to Molina Healthcare's specialty network, inter- provider communications, and pharmacy authorizations. This survey is conducted by an external vendor and is sent to a statistically valid, random sampling of Providers each year. If your office is selected to participate, please take a few minutes to complete it and send it back.

Effectiveness of Quality Improvement Initiatives

Molina Healthcare 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 a best practice. The Clinical Quality Improvement Committee (CQIC), which includes Members from the Provider network, evaluates clinical metrics on an ongoing basis. Results of these measurements guide activities for the successive periods.

Clinical Metrics include but are not limited to the following:

- Clinical Practice Guideline Compliance measurement:

- HEDIS measures for asthma, diabetes, and chlamydia screening
- Use of short-acting beta-agonists for Members with asthma
- Follow-up Chlamydia testing after positive result and treatment
- Use of antibiotics for upper respiratory disease

- Effectiveness of interventions in breathe with ease, Healthy Living with Diabetes, Heart Healthy Living, Chronic Obstruct Pulmonary Disease (COPD) programs:
  - Post-hospital follow-up rate with PCP or Specialist
  - Inpatient and emergency department utilization
  - Readmission after primary diagnosis of asthma, diabetes, COPD or a cardiovascular condition
  - Key clinical metrics including but not limited to: annual hemoglobin A1C and eye exams for diabetics and beta-blocker use and cholesterol testing after an acute cardiac event

- Service Improvement Metrics include but are not limited to:
  - UM authorization turnaround times
  - Pharmacy authorization turnaround times
  - Member Services response time
  - Satisfaction with Molina Healthcare specialty network (as measured through CAHPS® and Provider Satisfaction Survey)

Preventive Health, Health Education and Incentive Programs

Molina Healthcare integrates Health Education and Health Management Program goals with HEDIS Effectiveness of Care and Access rate improvement efforts. Member incentives continue to be successfully utilized to encourage Members to access important care and services.

Contracted Providers and Facilities must allow Molina Healthcare to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of quality improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

If you have any questions regarding these programs, please call our Health Education Line at **(855) 322-4076**.

Quality Enhancement Program

Molina Healthcare provides Quality Enhancements that are accessible to our Members in community settings and will collaborate with community agencies/organizations to offer services when possible.

Information regarding the Quality Enhancement programs is distributed to Molina Healthcare members and practitioners through a variety of mechanisms, including but not limited to new practitioner orientation materials, provider handbooks, member handbooks and the Molina Healthcare website.

Molina Healthcare offers Quality Enhancements (QE) to enrollees as specified below:

A. Molina Healthcare shall offer QEs in community settings accessible to enrollees.

B. Molina Healthcare shall provide information in the enrollee and provider handbooks on the QEs and how to access related services.

C. Molina Healthcare, Inc. shall develop and maintain written policies and procedures to implement the QEs.

D. Molina Healthcare may cosponsor the annual training of providers, provided that the training meets the provider training requirements for the programs listed below. Molina Healthcare, Inc. is encouraged to actively collaborate with community agencies and organizations, including CHDs, local Early Intervention Programs, Health Start Coalitions and local school districts in offering these services.

E. If the health plan involves the enrollee in an existing community program for purposes of meeting the QE requirement, the health plan shall ensure documentation in the enrollee's medical record of referrals to the community program and follow up on the enrollee's receipt of services from the community program.

F. The QEs available include but are not limited to the following:

1. Children's Programs - Molina Healthcare provides regular general wellness programs targeted specifically toward enrollees from birth to the age of five (5), or an alternative of making a good faith effort to involve the Member in an existing community Children's Program.

    - Children's programs shall promote increased use of prevention and early intervention services for at-risk enrollees. Molina Healthcare, Inc. shall approve claims for the services that are recommended by early intervention Programs when they are covered services and Medically Necessary. Molina Healthcare shall make a good faith effort to enter into and maintain agreements with the Local Early Intervention Program Office to establish methods of communication and procedures for the timely approval of services covered by Medicaid in accordance with s. 391.308, F.S.

    - Molina Healthcare, Inc. offers annual training to providers that promote proper nutrition, breast-feeding, immunizations, Well Child visits, wellness, prevention and early intervention services.

2. Domestic Violence - Molina Healthcare ensures that Primary Care Providers (PCP) screen Members for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies.

3. Pregnancy Prevention - Molina Healthcare conducts regularly scheduled Pregnancy Prevention Programs or an alternative of making a good faith effort to involve Members in existing community pregnancy prevention programs. The programs are targeted towards teen Members but are open to all Members regardless of age, gender, pregnancy status or parental consent.

4. Prenatal/Postpartum Pregnancy Programs - Molina Healthcare provides regular home visits, conducted by a home health nurse or aide, and counseling with educational materials to pregnant and postpartum Members who are not in compliance with the Plan prenatal and postpartum programs. Molina Healthcare shall coordinate its effort with local Healthy Start Care Coordinator to prevent duplication of services.

5. Behavioral Health Programs – Molina Healthcare shall provide outreach to homeless and other populations of enrollees at risk of justice system involvement, as well as those enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system

6. Smoking Cessation - Molina Healthcare shall conduct regularly scheduled smoking cessation programs as an option for all enrollees. Molina Healthcare, Inc. shall make a good faith effort to involve enrollees in existing community or Smoking Cessation programs. Molina Healthcare, Inc. shall provide participating PCPs with the Quick Reference Guide[1] to assist in identifying tobacco users and supporting and delivering effective Smoking Cessation interventions. (Molina Healthcare, Inc. shall obtain copies of the guide by contacting the DHHS, Agency for Health Care Research & Quality (AHR) Publications Clearinghouse at (800) 358-9295 or P.O. Box 8547, Silver Spring, MD 20907).

7. Substance Abuse - Molina Healthcare offers annual Substance Abuse screening training to its contracted Providers.

    - PCPs are required to screen Members for signs of Substance Abuse as part of prevention evaluation at the following times:

        - Initial contact with a new enrollee;
        - Routine physical examinations;
        - Initial prenatal contact;

- When the Member evidences serious over-utilization of medical, surgical, trauma or emergency services; and
- When documentation of emergency room visits suggests the need.

- Molina Healthcare offers targeted Members either community or Plan sponsored Substance Abuse Programs

Quality Improvement Committee

Molina Healthcare of Florida maintains a quality improvement committee that is a separate mechanism for addressing the quality improvement concerns of eligible frail members. The responsibilities of the quality improvement committee are as follows:

- Oversee quality of life indicators such as, but not limited to, the degree of personal autonomy, provision of services and supports to assist people in exercising medical and social choices, self-direction of care and maximum use of natural support networks.
- Review grievances and appeals identified through the Contractor's policies and procedures and through external oversight.
- Review case records of all fair hearings and document internal complaint/grievance steps involved in the fair hearing, as well as other pertinent information for the enrollee.
- Review quality assurance policies, standards, and written procedures to ensure that the needs of the enrollees are adequately addressed.
- Review utilization of services with adverse or unexpected outcomes for enrollees.
- Develop and periodically review written guidelines, procedures and protocols related to areas of concern in the care of the frail elderly.
- Develop an ethics committee to review ethical questions such as end-of-life decisions and advance directives.
- Develop a system of peer review by physicians and other service providers.

Risk Management Program

Molina Healthcare of Florida's Risk Management Program strives to provide quality care and service to our members. Risk Management is an integrated, company-wide program for the prevention, monitoring, and control of areas of potential liability exposure. It is the intent of Molina Healthcare of Florida, via the Risk Management Program to enhance the safety of patients, visitors, and employees; and minimize the financial loss to Molina Healthcare of Florida through risk detection, evaluation, and prevention.

Molina Healthcare of Florida maintains a risk management process that is designed to assure that network providers possess the credentials, including training and experience, to provide members the level of quality of care consistent with the mission of Molina Healthcare of Florida.

The program focuses on identification and prevention of risk exposures within the organization that could:

- Cause injury to patients, visitors, and employees
- Jeopardize the safety and security of the environment
- Result in costly claims and lawsuits with subsequent financial loss to the organization

The Risk Management Program is administered by the Quality Improvement Department. The Chief Medical Director and Director of Quality Improvement are responsible for the implementation and operation of the Risk Management Program which reports quarterly to the Quality Assurance Committee and to the Molina Healthcare of Florida Board of Directors.

Risk Adjustment Management Program

What is Risk Adjustment?

Risk Adjustment is a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information (age, gender, etc.)

This process helps ensure health plans receive accurate payment for services provided to our Members and prepares for resources that may be needed in the future.

Why is Risk Adjustment Important?

- Allows Molina to focus on quality and efficiency
- Enables us to recognize and address current and potential health conditions early
- Identifies Members for Case Management referral
- Ensures accurate payment for the acuity levels of our Members
- Most importantly, Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to our Members

Your Role as a Provider

As a provider your documentation in a Member's medical record is critical to Risk Adjustment and a Member's quality of care. For a complete and accurate medical record, all provider documentation must:

- Use the correct ICD-10 code by coding the condition to the highest level of specificity
- Only submit codes for diagnoses confirmed during a face to face visit with the Member
- Contain a treatment plan
- Be clear and concise
- Contain the Member's name and date of service
- Contain the physician's signature and credentials

RADV Audits

As part of the regulatory process, Risk Adjustment Data Validation (RADV) audits are conducted to ensure that diagnosis data submitted by Molina was accurate. All claims/encounters submitted

to Molina are subject to Federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to provide medical records to validate the data previously submitted.

Contact Information

For further questions about Molina's Risk Adjustment programs, please contact our team at: RiskAdjustment.Programs@MolinaHealthcare.com

Claims

As a contracted Provider, it is important to understand how the Claims process works to avoid delays in processing your Claims. The following items are covered in this section for your reference:

- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- Claims Disputes/Reconsiderations
- Billing the Member
- Fraud and Abuse
- Encounter Data

Hospital-Acquired Conditions and Present on Admission Program

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

The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

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

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; and

- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

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

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. Molina requests Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal). All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use EDI Claims/ Payor ID number - 51062.

To verify the status of your claims, please visit the Provider Portal or call our Provider Claims Representatives at the numbers listed below.

Claims
Address: Molina Healthcare of Florida PO Box 22812 Long Beach, CA 90801
Phone: (855) 322-4076
Email: MFLProviderServices@MolinaHealthcare.com
TTY: (800) 955-8771 (English) (800) 955-8773 (Spanish)
Provider Portal
https://provider.molinahealthcare.com

Providers must utilize electronic billing though a clearinghouse or Molina's Provider Portal, and use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 51062**.** For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

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

Required Elements

The following information must be included on every claim:

- 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 for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

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

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.

Electronic Claims Submission

Molina requires Participating Providers to submit Claims electronically. Electronic Claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID **51062**

Provider Portal:

Molina's Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

Clearinghouse:

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

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 contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com for additional support.

Coordination of Benefits and Third Party Liability

COB

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOBs and other required documents, by utilizing Molina's Provider Portal.

Third Party Liability

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within six (6) months 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, Provider must submit Claims to Molina within ninety (90) days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance

This information is intended to serve only as a general reference resource regarding Molina's Healthcare, Inc. reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation.

Providers are responsible for submission of accurate claims. This Reimbursement Guidance is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided.

Coding of both diagnoses and procedures is required for all claims. The coding schemes acceptable by the Division are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses and the CPT (Current Procedural Terminology) and HCPCS (The Healthcare Common Procedure Coding System) for procedures.

Molina Healthcare, Inc. utilizes a claims adjudication system that encompasses edits and audits to facilitate the State and Federal requirements. The claims adjudication system's exceptions used are based on nationally accepted standards, including but not limited to the American Medical Association's CPT guidelines, National Correct Coding Initiative (NCCI) edits, CMS standards and publications, and other related medical literature and proprietary software.

National Correct Cording 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 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 (MUEs) 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 electronic and paper claims. Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

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

Modifiers

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

- Service or procedure has a professional component

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

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

ICD-10-CM/PCS Codes

Effective 10/01/2015, Molina will utilize ICD-10-CM and PCS billing rules, and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. In order 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.

- Providers must submit ICD-10 codes for DOS or discharge on or after 10/01/2015. Claims containing ICD-9 codes for DOS on or after October 1, 2015, will be denied. Providers will be required to re-submit these claims with the appropriate ICD-10 code.
- If an inpatient hospital claim spans 9/30 & 10/1 and has an admission and/or from date prior to 10/1/15, then the entire claim should be billed using ICD-10 codes.
- Molina will deny all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim.
- Molina will only accept ICD-10 codes comprised of upper case characters. Any claim submitted with ICD-10 codes comprised of lower case characters will be denied.

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) specific pieces of information after the first digit, a leading zero (0). 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's) Official 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 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.

NDC

Effective May 1, 2014 the eleven (11) digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent.

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

Patient Responsibility

What is Patient Responsibility?

Patient Responsibility is the cost of Medicaid Long-Term Care (LTC) services not paid for by the Medicaid program, for which the member is responsible. Patient responsibility is the amount member must contribute toward the cost of their care. The amount of patient responsibility is determined by the Department of Children & Families (DCF) and is based on income and choice of residence.

Medicaid must reduce payments for Home and Community-Based Services (HCBS) provided under the Statewide Medicaid Managed Care (SMMC) LTC waiver, by the amount of the member's patient responsibility, in compliance with Title 42, Section 435.726, Code of Federal Regulations; and Section 2404 of the Affordable Care Act. This includes residents in Assisted Living Facilities (ALFs), Nursing Facilities (SNFs), Hospices, and Adult-Family Care Homes (AFCHs).

DCF calculates and determines member patient responsibility. Members are responsible for the patient responsibility determined by DCF when residing in a participating residential facility. **Providers are responsible for collecting patient responsibility *and* room and board for Molina members.** Molina will reduce payments made to SNF's, Hospices, ALF's and AFCH's by the amount of patient responsibility determined by DCF.

Submitting Documentation to DCF

The facility or member must provide DCF with documentation of the amount of the facility's basic room and board charges per month. The amount of the facility's basic room and board charges covers three (3) meals per day and a semi-private room. The amount of the facility's basic room and board charges does not cover any goods and services beyond three (3) meals per day and a semi-private room.

The member may submit the facility's documentation to DCF by uploading files online to their MyACCESS Account or, they, or the facility may submit documentation to DCF by either:

Faxing the documentation to: (866)-886-4342 or mailing the documentation to:

ACCESS Central Mail Center
PO Box 1770
Ocala, FL 34478-1770

Uncovered Medical Expense Deduction

An Uncovered Medical Expense Deduction (UMED) may occur when the Molina member incurs a charge for a medically necessary service that is not covered by a third party payer, Medicare, MMA, or LTC. Examples of qualified UMEDs are: a premium, deductible, or coinsurance charge for health insurance coverage or medical expenses that are approved by DCF.

DCF may change the monthly amount of patient responsibility and determine to increase the amount of the member's patient responsibility due to an increase in the member's income or decrease the amount of patient responsibility due to a DCF approved UMED. DCF will notify members when there is a change in the monthly amount of patient responsibility by mailing a Notice of Case Action (NOCA) to the member.

Members must notify DCF within ten (10) days of receiving a bill/receipt of what medical expenses (paid or unpaid) they have to pay. The member may submit the proof of medical expenses to DCF by uploading files online to their MyACCESS Account, by faxing the documentation to: (866)-886-4342 or mailing the documentation to:

ACCESS Central Mail Center
PO Box 1770
Ocala, FL 34478-1770

Verifying Member Patient Responsibility

Providers may view member patient responsibility information via the 'DCF Provider View' option in the Florida Medicaid Secure Provider Web Portal found at:
https://sso.flmmis.com/adfs/ls/?wa=wsignin1.0&wtrealm=https%3a%2f%2fsso2.flmmis.com%2fadfs%2fls%2fid&wctx=d19e0a5d-f160-413b-936d-7f68bde377d4&wct=2016-10-10T18%3a52%3a50Z&whr=https%3a%2f%2fsso.flmmis.com%2fadfs%2fls%2fid

Providers may also contact DCF if there are any questions about the information found on the DCF Provider Portal or if they are unable to obtain needed information by contacting the DCF Customer Call Center at: (866)-762-2237.

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

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's 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. 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.

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and must include the original claim number in the resubmission field for claims submitted manually or electronically.

Claims submitted without the correct coding will be returned to the Provider for resubmission.

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
    - "1"-ORIGINAL (initial claim)
    - "7"–REPLACEMENT (replacement of prior claim)
    - "8"-VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the "1" "7" or "8" goes in the third digit for "frequency".
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

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 six (6) months after receipt of Clean Claims.

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

Electronic Claim Payment

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

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, 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.

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.

Refund Requests may be sent to:

Molina Healthcare of Florida
Cost Recovery Department
PO Box 741037
Atlanta, GA 30374-1037

Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within one (1) year of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Provider Dispute/Appeal Form found on Provider website and the Provider Portal. ***The form must be filled out completely in order to be processed.*** Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following:

Providers should submit the following documentation:

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

Forms may be submitted via fax, secure email or mail. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address:

Molina Healthcare of Florida, Inc.
Attention: Grievance & Appeals Department
PO Box 527450
Miami, FL 33152-7450

Submitted via fax:

(877) 553-6504

Secure email:
MFL_ProviderAppeals@MolinaHealthcare.com

Claims denied for missing documentation such as consent forms, explanation of benefits from primary carrier, or itemized bills are not disputes. These must be submitted within 35 days from the date of the Explanation of payment. Please mail those requests with the copy of the claim to:

Molina Healthcare of Florida
P.O. BOX 22812
Long Beach, CA 90801

Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

The Provider will be notified of Molina's decision in writing within sixty (60) days of receipt of the Claims Dispute/Adjustment request.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
    - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
    - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
    - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse

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

Encounter Data

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

Encounter data must be submitted at least once per month, and no later than seven (7) days following the date on which the Molina adjudicates the claims 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. For institutional services, only those services covered by Molina should be reported.

Molina shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

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 will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction

Hospitals

This section includes policies and procedures specific to contracted hospitals. We have included information pertaining to Emergency Care, Admissions, Newborn Reporting Requirements and Claims.

Emergency Services

Emergency services are covered twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (365) days a year, for all Members experiencing an emergency medical situation.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of the Member, including a pregnant woman or fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- A pregnant woman with contractions or rupture of membrane

Molina Healthcare ***shall not****:*

- Require prior authorization for a Member to receive pre-hospital transport or treatment or for emergency services and care;
- Specify or imply that emergency services and care are covered by Molina Healthcare only if secured within a certain period of time;
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
- Deny payment based on a failure by the enrollee or the hospital to notify Molina Healthcare before, or within a certain period of time after, emergency services and care were given.

Molina Healthcare shall cover pre-hospital and hospital-based trauma services and emergency services and care to Members.

When a Member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician.

- The physician, or the appropriate personnel, shall indicate on the Member’s chart the results of all screenings, examinations and evaluations

- Molina Healthcare shall cover all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the Member's condition is an emergency medical condition.
- If the provider determines that an emergency medical condition does not exist, the Managed Care Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Managed Care Plan.

If the provider determines that an emergency medical condition exists, and the Member notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is a Member of Molina Healthcare, the hospital must make a reasonable attempt to notify:

- The Member's PCP, if known;
- Molina Healthcare, if the Health Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, does not know the Member's PCP, or has been unable to contact the PCP, the hospital must:

- Notify the Health Plan as soon as possible before discharging the Member from the emergency care area,
- Notify Molina Healthcare within twenty-four (24) hours or on the next business day after the Member's inpatient admission.

If the hospital is unable to notify Molina Healthcare, the hospital must document its attempts to notify Molina Healthcare, or the circumstances that precluded the hospital's attempts to notify the Plan. Molina Healthcare shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.

Molina Healthcare shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as Molina Healthcare can safely transport the enrollee to a participating facility. Molina Healthcare may transfer the Member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the Member's emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

Post-Stabilization Care Services

Molina Healthcare shall cover post- post-stabilization care services without authorization, regardless of whether the Member obtains a service within or outside the Plan's network for the following situations:

- Post-stabilization care services that were pre-approved by the Health Plan

- Post-stabilization care services that were not pre-approved by the Health Plan because the Health Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request.
- The treating provider could not contact the Health Plan for pre-approval.
- Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Health Plan can choose not to cover them if they are provided by a non-participating provider, except in those circumstances detailed above.

Admissions

Hospitals, Assisted Living Facilities (ALF), and Nursing Facilities (SNF) are required to notify Molina Healthcare within twenty-four (24) hours or the first working day of any inpatient admissions, including deliveries, in order for eligible services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Notification of admission must include clinical information needed to determine the appropriateness of the admission. Inpatient hospitalizations are covered by Medicare fee-for-service program or the member's Medicare Advantage plan.

Therapies in Hospitals

All Therapy Services, including the Initial Evaluation, rendered in an Outpatient Hospital Setting will require a Prior Authorization for all Lines of Business.

Please note, Therapy Services in an Outpatient Hospital Setting will only be pre-authorized for Special Needs members, Continuity of Care, or lack of available free-standing facilities in the members' area. Please refer member to Ordering Physician to discuss alternative options within Health Network One's network.

If member meets any of the above criteria, any ordering physician that requests Therapy services in a Hospital must submit supporting clinical documentation (Progress notes, Continuity of Care, Prescription, etc.) clarifying the need for a Hospital setting. Authorization requests without supporting documentation may cause a delay in processing.

The Prior Authorization Guide and Pre-Service Request Form may be found on Molina's website at: www.MolinaHealthcare.com.

For community-based therapy services in freestanding facilities, please utilize Molina's freestanding therapy vendor, **Health Network One/American Therapy Administrators.**

- **Health Network One/American Therapy Administrators**: 1-888-550-8800, Monday through Friday, 8:30 AM through 5:00 PM or visit their website at www.ataflorida.com.

For Long-Term Care members, please contact Molina Healthcare.

Newborn Reporting Requirements

Molina Healthcare must ensure that it notifies the Department of Children and Families (DCF) upon notification from the Hospital that a pregnant member has presented to the hospital for delivery.

Hospitals are required to notify Molina Healthcare when a pregnant Member presents to the hospital for delivery and provide information to Molina Healthcare that may be required for Molina Healthcare to complete the state's Newborn Activation Form DCF-ES 2039. This form is located at http://www.fdhc.state.fl.us/Medicaid/Newborn.

Claims Submission

Claims must be submitted to Molina Healthcare with appropriate documentation electronically for CMS-1500 claims and UB-04 claims. Electronic claims may be submitted via EDI through a Clearinghouse, or through the Molina Provider Portal.

Providers billing Molina Healthcare electronically should use EDI Payor ID number - 51062

Molina Healthcare will only process claims containing the essential data requirements. If claim information is inaccurate or incomplete, a request will be issued on the provider's RA for additional information.

Providers shall promptly submit to Molina Healthcare, claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare's policies and procedures. Provider can send claims with attachments by utilizing the Provider Portal. Claims must be submitted by Provider to Molina Healthcare within six (6) months after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and Provider has been furnished with the correct name and address of the Member's health plan. If Molina Healthcare is not the primary payer under coordination of benefits, Provider must submit claims to Health Plan within ninety (90) days after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Health Plan within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

Claim Editing Process

Molina Healthcare has a claims pre-payment auditing process that identifies frequent billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered

Coding edits are generally based on Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative guidelines. If you disagree with an edit *please refer to* ***Complaints, Grievance and Appeals Process,*** Provider Disputes section.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a Member, it will make a claim for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare's claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within sixty (60) days after the date on which the overpayment was identified.

A provider that denies or contests an organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within (35) days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within (35) days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within (45) days after receipt of the information.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment. An overdue payment of a claim bears simple interest at the rate of (10) percent a year. Interest on an overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment has been received.

A provider shall pay or deny any claim for overpayment no later than (120) days after receiving the claim. Failure to do so creates an uncontestable obligation for the provider to pay the claim to the organization.

HIPAA

Molina Healthcare's Commitment to Patient Privacy

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

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted Providers/Practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Providers must develop and implement confidentiality procedures to guard member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable federal and state regulations. Providers must ensure their staff receives periodic training regarding the confidentiality of Member information.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare 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/Practitioners must comply with. In general, most healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
    - HIPAA
    - Medicare and Medicaid laws
2. Applicable State of Florida Laws and Regulations

Providers/Practitioners 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/Practitioners 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/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI.

Uses and disclosures for TPO apply not only to the Provider/Practitioner'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 healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

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

2) A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality improvement
- Disease management;
- Case management and care coordination;
- Training Programs;
- Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

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 Healthcare Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner's practice:

Notice of Privacy Practices

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

Requests for Restrictions on Uses and Disclosures of PHI

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

Requests for Confidential Communications

Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

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

Requests for Patient Access to PHI

Patients have a right to access their own PHI within a Provider/Practitioner'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/Practitioner includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

Request to Amend PHI

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

Request Accounting of PHI Disclosures

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

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare 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 healthcare 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 Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare requires the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers/Practitioners must submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions 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 Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners should refer to Molina Healthcare's website at: http://www.molinahealthcare.com for additional information on HIPAA standard transactions.

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at: http://www.molinahealthcare.com for additional information.

National Provider Identifier

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

Additional Requirements for Delegated Providers/Practitioners

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

Fraud, Waste, & Abuse

Introduction

Molina Healthcare of Florida maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. Molina Healthcare of Florida is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare of Florida will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina's Special Investigation Unit supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of Florida.

Mission Statement

Molina Healthcare of Florida regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina Healthcare of Florida has therefore implemented a program to 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, including the Medicare and Medicaid programs. 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.

Florida False Claims Act

Florida has also enacted a state False Claims Act (F.S. Title VI, §§ 68.081-68.089) in 2007 to allow for the recovery of state funds in addition to federal funds for false claims. The provisions of the Florida False Claims Act (FFCA) are similar, but not identical to, the provisions of the federal FCA. The FFCA provides for civil penalties of not less than $5,500 and not more than $11,000 per violation, for three times the damages to state government due to false claims, and for recovery of attorney's fees and court costs.

Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act ("DRA") was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Florida who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare of Florida, 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 a whistleblowers.

Whistleblower Protection

The Federal False Claims Act, the Florida False Claims Act, and the Medicaid False Claims Act have Qui Tam language commonly referred to as "whistleblower" provisions. 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 acts. 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 Healthcare will take steps to monitor Molina Healthcare of Florida contracted providers to ensure compliance with the law.

Definitions

Fraud:

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself 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. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

Abuse:

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

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding", and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of Florida identification card.
- Failure to report a patient's forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.

- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)

Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities including the Florida Agency for Healthcare Administration's list of suspended and terminated providers at: http://apps.ahca.myflorida.com/dm_web
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible provider list.
- Monthly review of state Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Profiling

Molina Healthcare of Florida performs claims audits to detect potential external health care fraud, waste, or abuse. These audits of provider billings are based on objective and documented criteria. Molina Healthcare of Florida uses a fraud, waste, and abuse detection software application designed to score and profile provider and member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or member's prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. If a score reaches a certain parameter or threshold, the provider or member is placed on a list for further review.

Molina Healthcare of Florida will inform the provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

Provider/Practitioner Education

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

The Molina Healthcare of Florida Provider Services Representative will inform the provider's office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

Molina Healthcare Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

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

Molina Healthcare of Florida 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.

Cooperating with Special Investigation Unit Activities

Molina Healthcare's Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities, and will provide requested documentation to the unit following the timelines indicated in such requests. Failure to cooperate may result in further action, up to and including termination of the Provider contract.

Reporting Fraud, Waste and Abuse

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

Molina Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service's website to make a report at any time at: https://molinahealthcare.alertline.com

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

Molina Healthcare of Florida
Attn: Compliance Department
8300 NW 33rd St, Suite 400
Doral, FL 33122

Remember to include the following information when reporting:

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

To report suspected fraud and/or abuse in Florida Medicaid, call the **Consumer Complaint Hotline toll- free at 1-888-419-3456** or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/

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

Department of Financial Services
Division of Insurance Fraud
200 East Gaines Street
Tallahassee, FL 32399-0318
Toll Free Phone: (877) 693-5236

Florida Attorney General
Fraud Hotline: (866) 966-7226

If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (**toll-free (866) 966-7226 or (850) 414-3990**). The reward may be up to twenty- five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Credentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Molina Provider Services representative.

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

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

Non-Discriminatory Credentialing and Recredentialing

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

Types of Practitioners Credentialed & Recredentialed

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

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare Practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

Credentialing Turn Around Time

Molina fully enrolls/on-boards initial Practitioners within sixty (60) calendar days. The sixty (60) calendar days is measured from the date Molina receives a full and complete credentialing application.

Criteria for Participation in the Molina Network

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Molina network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meets all criteria for initial participation and continued participation in the Molina network. If the Practitioner fails 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** – Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within one-hundred-twenty (120) days. Application must include all required attachments.
- **License, Certification or Registration** – Provider must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located and the State the member is located.
- **DEA or CDS Certificate** – Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number. If a Practitioner does not have a DEA or CDS because it has been revoked, restricted or relinquished due to disciplinary reasons, the Practitioner is not eligible to participate in the Molina network.
- **Specialty** – Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Molina Members.

- **Education** –Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training** – Provider 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 (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.
- **Fellowship Training** – If the Provider is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:

    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery
    - American Board of Addiction Medicine (ABAM)
    - College of Family Physicians of Canada (CFPC)
    - Royal College of Physicians and Surgeons of Canada (RCPSC)
    - Behavioral Analyst Certification Board (BACB)
    - National Commission on Certification of Physician Assistants (NCCPA)

- **General Practitioners** – Practitioners who are not board certified and have not completed 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 (5) years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or Wound Care. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.

- **Work History** – Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.
- **Malpractice History** – 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 in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Molina will also verify all licenses, certifications and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[1]. 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 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.

[1] 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.

- **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 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** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any criminal convictions. Practitioners must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacturing, distribution or dispensing of a controlled substance.
- **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** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

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

Molina will notify the Practitioner immediately in writing in the event credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification, 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's rights are published on the Molina website and are included in this Provider Manual.

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

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.

- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Practitioner's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director at PO Box 2470, Spokane, WA 99210

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

If the Practitioner does not respond within ten (10) calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Manual.

The Practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Practitioner are documents, which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner's rights are published on the Molina website and are included in this Provider Manual. Molina will respond to the request within two (2) working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than sixty (60) calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

Molina recredentials every Practitioner at least every thirty-six (36) months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality are identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

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

Molina also monitors the following for all Provider types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Active Patient Load Attestation

Practitioner must complete, sign and date an 'Attestation and Release of Information' form attesting to their active patient load. The form must be completed in its entirety by answering the following questions:

- Practitioner's patient load (all patient populations including but not limited to Medicaid fee for service; Children's Medical Services Network; SMMC plans; Medicare; KidCare and commercial coverage) is no more than three-thousand (3,000) patients per PCP.
- An active patient is seen by the Practitioner a minimum of three (3) times a year.
- The Practitioner is eligible to become a Medicaid provider.

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider's contract based on quality of care or professional conduct, a certified letter is sent to the Provider describing the adverse action taken and the reason for the action, including notification to the Provider of the right to a fair hearing when required pursuant to Laws or regulations.

Complaints, Grievance and Appeals Process

Molina Healthcare Members or Member's personal representatives have the right to file a complaint, grievance and submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina Healthcare's Member Grievance and Appeals Process.

Member Complaints, Grievance & Appeals Process

If a Member is unhappy with the service from Molina Healthcare or providers contracted with Molina Healthcare, they may file a complaint or a formal grievance by contacting Member Services toll-free at (866) 472-4585, Monday – Friday 8 a.m. – 7 p.m. They can also write to us at:

Molina Healthcare of Florida
Attention: Grievance & Appeals Department
P.O. Box 521838
Miami, FL 33152

Members may also send their written grievance via fax to: (877) 508-5748 or submit via email at: MFLGrievanceandAppeals@MolinaHealthcare.com

Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the Member handbook, Member newsletters and Molina Healthcare's website: website: www.molinahealthcare.com. Members are notified of these rights upon enrollment, and annually thereafter. Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a Member in making decisions related to health care or is a legal representative of the Member, MHF will treat such person as a personal representative.

If the Member/Provider registers an informal complaint, Molina Healthcare will attempt to resolve the complaint within 24 hours. If the complaint cannot be resolved, it will be treated as a formal grievance. A member may file a grievance orally or in writing at any time.

A member, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination.

Members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for Members with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

All grievances whether oral or in writing, and Appeals (oral, followed by written confirmation within five {5} days of) are documented by the Member Services Department in all appropriate systems, and written acknowledgement is sent to all parties.

Any issues related to a clinical denial and/or appeal of a coverage decision, is referred to the Utilization Management Department to review the medical necessity aspects of the request.

A person not involved in the previous decision-making process reviews the grievance or appeal to determine the resolution. In appeals involving denial of clinical services, health care professionals with appropriate expertise conduct the review. A Medical Director of same or similar specialty who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination will review the appeal and make the determination.

All grievance and appeal requests concerning admissions, continued stay, immediate care issues, or other services for Members who have received emergency services but have not been discharged from a facility are granted an Expedited Review. Expedited Reviews are completed as promptly as the medical condition requires, but no later than three (3) days after the request.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) and/or Critical Incidents issues is referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

All grievance decisions are made within state established time frames not to exceed ninety (90) calendar days from the day the initial grievance or appeal is received. However, the grievance process time-frame may be extended up to fourteen (14) calendar days if the Member voluntarily agrees to an extension or the Managed Care Plan documents that additional information is needed and the delay is in the enrollee's interest. If the timeframe is extended other than at the enrollee's request, the Managed Care Plan shall notify the enrollee within five (5) business days of the determination, in writing, of the reason for the delay. All appeal decisions are made within state established time frames not to exceed thirty (30) calendar days from the day the initial grievance or appeal is received. However, the appeal process time-frame may be extended up to (14) calendar days if the Member voluntarily agrees to an extension.

All aspects of the review process are documented and tracked in Molina Healthcare's core data maintenance application and Grievance and Appeal database.

Members also have the right to appear in person and/or appoint a representative to act and speak on the Member's behalf at any point in the grievance and appeals process.

A member who has completed the Managed Care Plan's appeal process may file for a Medicaid Fair Hearing within one hundred twenty (120) calendar days of receipt of the notice of plan appeal resolution. To request a Fair Hearing, Members/Member representative, should contact:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
Phone: (877) 254-1055
Fax: (239) 338-2642
MedicaidHearingUnit@ahca.myflorida.com

Molina Healthcare shall continue the Member's benefits if the Member or the Member's authorized representative submits a request for appeal within ten (10) business days after the Notice of Adverse Benefit Determination is mailed, or on or before the intended effective date of the action, whichever is later.

If the final resolution of the appeal is adverse to the Member and the action is upheld, Molina Healthcare may recover the cost of services furnished to the Member while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.

Expedited Appeal

An appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a Member's life or materially jeopardize a Member's health. A request to expedite may come from the Member, a provider, or when Molina Healthcare feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within forty-eight (48) hours.

Reporting

All Grievance/Appeal data, including practitioner specific data, is reported quarterly to 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 Committee quarterly. Annually, a quantitative/qualitative report will be compiled and presented to 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.

Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues. Appeals and Grievances will be reported to the State quarterly.

Record Retention

Molina Healthcare will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically in Molina Healthcare's core processing system or maintained in other electronic files, Molina Healthcare will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process.

Second Opinion

If a Member does not agree with their provider's plan of care, they have the right to a second opinion from another provider. Member can call Member Services to find out how to get a second opinion.

Provider Complaint Process

Provider Disputes and Appeals

Molina Healthcare is committed to the timely resolution of all provider complaints. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. Provider disputes are typically disputes related to overpayment, underpayments, untimely filing, missing documents (i.e. consent forms, primary carrier explanation of benefits) and bundling issues. Provider Appeals are requests related to a denial of an authorization or medical criteria.

Providers disputing a Claim previously adjudicated must request such action within one (1) year of Molina's original remittance advice date. A written acknowledgement letter will be mailed within three (3) business days of receipt of a claim dispute or appeal. In addition a written notice of the status of your request will be mailed every 15 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within sixty (60) days of receipt of the claim dispute or appeal in accordance with 641.3155, F.S.

Molina has a dedicated staff for providers available to receive and resolve claim dispute and appeals. Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Florida via the Provider Portal. https://provider.molinahealthcare.com.
- Submit requests directly to Molina Healthcare of Florida via fax at: 877-553-6504
- Submit Provider Disputes impacting more than 10 claims can be submitted via email to MFLClaimsDisputesProjects@MolinaHealthCare.Com
- Submit Provider Appeal request to MFL_ProviderAppeals@MolinaHealthcare.com Submit Provider Disputes through the Contact Center at 866-472-4585 (Monday – Friday, 8am – 7pm)
- Submit requests via mail to:

Molina Healthcare of Florida
Provider Dispute and Appeals
P.O. BOX 527450
Miami, FL 33152-7450

Please note:

- Claims denied for missing documentations such as consent forms, explanation of benefits from primary carrier, or itemized bills are not disputes. These must be submitted within 35 days from the date of the Explanation of payment. Please mail those requests with the copy of the claim to:

Molina Healthcare of Florida
P.O. BOX 22812
Long Beach, CA 90801

- Requests for adjustments of claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original claim.

Maximus

If the Provider Dispute/Appeal results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute/Appeal for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Maximus Federal Services State Appeals Process
50 Square Drive
Suite 120
Victor, NY 14564
Tel. (866) 763-6395
Fax (585) 425-5296

Provider Complaints Not Related to Claims

Providers with complaints not related to claims have forty-five (45) days to file a written complaint. A written acknowledgement letter will be mailed within three (3) business days of receipt of complaint. In addition a written notice of the status of your request will be mailed every 15 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within ninety (90) days of receipt and provided written notice of the disposition and the basis of the resolution within three (3) business days of resolution.

To file a Provider Complaint not related to claims, providers may contact Member Services at (866) 472- 4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida, Inc.
Attention: Provider Dispute and Appeal
P.O. Box 527540
Miami, Florida 33152-7540

Subcontractor Complaints Information

Subcontractor Provider Complaints Information	
Transportation	**Access2Care** • **Mailing Address:** Access2Care,16331 Bay Vista Drive, Clearwater, FL 33760 • **Contact Number:** 844-814-4092. • **Fax Number:** 888-305-8246 • **Email**: SRTSouth@amr.net

Therapy	**Health Network One** • **Mailing Address:** Health Network One, Inc., P.O. Box 350590, Fort Lauderdale, FL 33335-0590 • **Contact Number:** 1.888.550.8800 • **Fax Number:** 305-620-5973 • **Email:** ATAFL@healthnetworkone.com
DME, Home Health, Home Infusion	**Coastal Care** • **Mailing Address:** Coastal Care Solutions, 7875 NW 12 ST, Suite 200, Miami, FL 33126 • **Contact Number:** 1-855-481-0505 • **Website:** www.ccsi.care
Behavioral Health	**Beacon Health** • **Mailing Address:** Beacon Health Options Attention: Grievance & Appeals Department, P.O. 1872, Hicksville, NY 11802-1872. • **Contact number**: 855-371-3945 (Medicaid) 855-371-9230 (Medicare/Exchange) • **Fax Number:** 305-722-3013 • **Email**: miami_partners@beaconhealthoptions.com • **Website**: www.beaconhealthoptions.com
Vision	**iCare Solutions** • **Mailing Address:** iCare Provider Relations; 5440 Mariner Street, Suite 112, Tampa, FL 33609 • **Contact Number** (855) 373-7627 • **Email:** grievances@myicarehealth.com • **Website:** eHealthDeck.com

Delegation

This section contains information specific to Molina's delegation criteria. Molina may delegate certain administrative responsibilities upon meeting all of Molina's delegation criteria. Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

Delegation Criteria

Sanction Monitoring

All sub-contractors of Molina are required to show proof of processes to screen staff and employees at all levels against Federal exclusions lists. Screening must done prior to the employee/staff's hire date,

and occur monthly thereafter. Molina will include a Sanction Monitoring pre-assessment audit with all other pre-assessment audits, any time a function(s) is/are being considered for delegation.

Sanction Monitoring functions may be delegated to entities which meet Molina criteria. To be delegated for sanction monitoring functions, Providers must:

- Pass Molina's sanction monitoring pre assessment, which is based on CMS standards.
- Demonstrate that employees and staff are screened against Office of Inspector General (OIG) and System for Award Management (SAM) sanction lists prior to hire dates, and monthly thereafter.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for sanction monitoring delegates.
- Submit timely and complete Sanction Monitoring delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When staff or employees are identified as having a positive sanction, provide Molina with notification according to Contractual Agreements of the findings and action(s) being taken to ensure sanctioned staff is not providing services to Molina Members.

Credentialing

Credentialing functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA©) criteria for credentialing functions. To be delegated for credentialing functions, Providers must:

- Pass Molina's credentialing pre-assessment, which is based on NCQA© credentialing standards.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG and SAM exclusion lists a minimum of every thirty (30) days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.

Note: If the Provider is an NCQA© Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA© accredited or certified in Credentialing functions, or demonstrate an ability to meet all Health Plan, NCQA©, and State and Federal requirements identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be completed on

the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of non-compliance are identified.

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

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Contract Manager.

CMS Preclusion List

All subcontractors delegated for Credentialing and/or Claims Administration must review their practitioner network against the CMS Preclusion list. The CMS Preclusion list will be provided to the subcontractor on a monthly basis by Molina Healthcare. Within five (5) business days of receipt, the subcontractor must review the list and identify any practitioners with a new preclusion since the last publication date. Within fifteen (15) calendar days of receipt of the list, the subcontractor must notify Molina of any identified practitioner(s), including a report of all Molina claims paid to the provider in the previous twelve (12) months. Depending on delegated expectations, subcontractors may also be responsible for sending the necessary Member notification at least sixty (60) calendar days prior to the Preclusion effective date, informing the Member of the need to select a new practitioner.

Note: Member notification responsibilities depend on the functions delegated and the services provided. Not all subcontractors are responsible for this piece, and in some cases, are required to send the appropriate information to Molina so that Molina can notify impacted Members. If there are questions about subcontractor responsibilities related to Member notification of precluded providers, please contact your Molina Delegation Oversight contact.

Glossary of Terms

Action – The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

I. Constant availability of medical supervision by attending Provider or other medical staff
II. Constant availability of licensed nursing personnel
III. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the Provider

AHCA – Agency for Health Care Administration

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a Provider, including but not limited to laboratory services, radiology services, and physical therapy.

Appeal – An oral or written request by a Member or Member's personal representative received at Molina Healthcare for review of an action.

Authorization – Approval obtained by Providers from Molina Healthcare for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Children With Special Health Care Needs (CSHCN) – Children identified by HRSA as meeting the federal guidelines under Title V of the Social Security Act (SSA). Any child (birth to (18) years of age) with a health or developmental problem requiring more than the usual pediatric health care.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that Provider status be extended only to professional, competent Providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.

Current Procedural Terminology (CPT) Codes – American Medical Association (AMA) approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, Providers' offices and home health care.

Denied Claims Review – The process for Providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a Provider.

Dual Coverage – When a Member is enrolled with two Molina Healthcare plans at the same time.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Emergency Care – The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Encounter Data – Molina Healthcare shall collect, and submit to the Agency's fiscal agent, enrollee service level encounter data for all covered services.

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.

Expedited Appeal – An oral or written request by a Member or Member's personal representative received by Molina Healthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function; or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance – A grievance where delay in resolution would jeopardize the Member's life or materially jeopardize the Member's health.

Federally Qualified Health Center (FQHC) – A facility that is:

I. Receiving grants under section 329, 330, or 340 of the Public Health Services Act
II. Receiving such grants based on the recommendation of AHCA within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant
III. A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638)

Fee-For-Service (FFS) – FFS is a term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a Member.

Grievance – An oral or written expression of dissatisfaction by a Member, or representative on behalf of a Member, about any matter other than an action received at Molina Healthcare.

Health Plan Employer Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, Provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPAA – Health Insurance Portability and Accountability Act

Independent Practice Association (IPA) – A legal entity, the Members of which are independent Providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the Member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a Member.

Medically Necessary Services – FS 409.9131 (2) (b) Any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration

of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare Provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous Member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

Participating Provider – A Provider that has a written agreement with Molina Healthcare to provide services to Members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of Providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a Provider or Provider group that may directly or indirectly have the effect of reducing or limiting services to Members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating Provider responsible for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to; Pediatricians, Family Practice Providers, General Medicine Providers, Internists, Obstetrician/Gynecologists, Physician Assistants (under the supervision of a Physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by Molina Healthcare.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another Provider for services or consultation which the referring Provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled Members.

Service Area – A geographic area serviced by Molina Healthcare, designated and approved by AHCA.

Specialist – Any licensed Provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Florida Kidcare/State Children's Health Insurance Plan (SCHIP) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by HRSA.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

Sub-Contract – A written agreement between a health plan and a participating Provider, or between a participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Telemedicine — The practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than Molina Healthcare liable for payment of health care services rendered to Members. Molina Healthcare will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for SCHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Well Child Visit (formerly known as CHCUP) – Early Periodic Screening Diagnosis and Treatment Program

**********END OF HANDBOOK**********

MOLINA HEALTHCARE
Your Extended Family

MOLINA HEALTHCARE
MMA/LTC PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 1/1/2020

Molina Healthcare
Medicaid Prior Authorization/Pre-Service Request Form

Phone Number: 1 (855) 322-4076
Fax Number: 1 (866) 440-9791

MEMBER INFORMATION			
Plan:	☐ **Molina Medicaid (MMA)**	☐ **Long-Term Care**	
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐Elective/Routine	☐Expedited/Urgent*	

***Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

REFERRAL/SERVICE TYPE REQUESTED		
Inpatient ☐Surgical procedures ☐Admissions ☐SNF ☐LTAC	**Outpatient** ☐Surgical Procedure ☐OT ☐PT ☐ST ☐Diagnostic Procedure ☐Infusion Therapy ☐Pain Management ☐Other: _____	☐ **Home Health** ☐ **DME** ☐ **In Office**

Diagnosis Code & Description:			
CPT/HCPC/J Code & Description*:			
Strength/Dosage & Frequency for above J-Codes**			
Number of visits requested:		DOS From: / /	to / /

Please send clinical notes and any supporting documentation.

***All labs should be sent to a Participating Laboratory**

****If multiple CPT or J-Codes, please submit this form along with a separate attachment.**

PROVIDER INFORMATION					
Requesting Provider Name:		NPI#:		TIN#:	
Servicing Provider or Facility:		NPI#:		TIN#:	
Contact at Requesting Provider's office:					
Phone Number:	( ) -	Fax Number:	( ) -		
For Molina Use Only:					

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.

MOLINA HEALTHCARE

Your Extended Family.