Provider Manual

Molina Healthcare of South Carolina

(Molina Healthcare, Molina or Molina Dual Options)

Molina DualOptions Medicare-Medicaid Plan

Medicare-Medicaid 2021

MOLINA® HEALTHCARE

Healthy Connections PRIME

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at MolinaHealthcare.com/Duals.

Last Updated: February 2021

Contents

I. Medicare-Medicaid Products

Medicare-Medicaid Products Overview

Molina Dual Options is the brand name of Molina's Medicare-Medicaid Program (MMP).

Molina Dual Options (MMP)

Molina Dual Options is the name of Molina's Medicare-Medicaid Program. The Dual Options plan in South Carolina was designed for Members of the Healthy Connections Prime program in order to provide quality health care coverage and service with little out-of-pocket costs. Dual Options embraces Molina's longstanding mission to serve those who are the most in need and traditionally have faced barriers to quality health care.

Please contact the Provider Services Department toll free at (855) 237-6178, TTY: 711 from 8:00 a.m. to 8:00 p.m. local time Monday through Friday with questions regarding this program.

II. Addresses and Phone Numbers

Molina Dual Options- South Carolina
PO Box 40309
North Charleston, SC 29423-0309

PROVIDER SERVICES		
The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Services representatives who serve all of Molina Dual Options' Provider network Monday through Friday from 8 a.m. to 8 p.m., local time. Eligibility verifications can be conducted at your convenience via the Provider Portal.	Telephone	(855) 237-6178
MEMBER SERVICES		
The Member Services department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services representatives are available 7 days a week, 8 a.m. to 8 p.m., local time, excluding State holidays. Eligibility verifications can be conducted at your convenience via the Provider Portal.	Telephone	(855) 735-5831, TTY/TDD: 711
NURSE ADVICE LINE		
This telephone-based Nurse Advice Line is available to all Molina Dual Options Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week to assess symptoms and help make good health care decisions.	English Telephone	(888) 275-8750
	Spanish Telephone	(866) 648-3537
	Hearing Impaired (TTY)	711

CLAIMS DEPARTMENT		
Molina Dual Options strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or Provider Portal) whenever possible. Access the Provider Portal (https://provider.MolinaHealthcare.com) EDI Payer ID 46299. To verify the status of your Claims, please use the Provider Portal. For other Claims questions contact Provider Services. Mailing Address: Molina Dual Options Claims PO Box 22664 Long Beach, CA 90801 EDI: Payer ID 46299 Physical Address for Overnight Packages: Molina Dual Options of South Carolina PO Box 40309 North Charleston, SC 29423-0309	Telephone	(855) 237-6178
CLAIMS RECOVERY DEPARTMENT		
The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims. Molina Healthcare of South Carolina. PO Box 40309 North Charleston, SC 29423-0309	Telephone	(855) 237-6178

COMPLIANCE/FRAUD ALERTLINE		
If you suspect cases of fraud, waste, or abuse, you must report it to Molina Dual Options. You may do so by contacting the Molina Dual Options AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance section of this Provider Manual. Confidential Compliance Official Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802	Telephone	(866) 606-3889
	Website	https://MolinaHealthcare.AlertLine.com
CREDENTIALING DEPARTMENT		
The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years, or sooner, depending on Molina Dual Options's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina Dual Options network. Molina Dual Options Credentialing Department Molina Dual Options of South Carolina PO Box 40309 North Charleston, SC 29423-0309	Telephone	(855) 237-6178
	Fax	(843) 740-1748

QUALITY IMPROVEMENT		
Molina Dual Options maintains a Quality Improvement (QI) department to work with Members and Providers in administering the Molina Dual Options Quality Program. Molina Dual Options of South Carolina PO Box 40309 North Charleston, SC 29423-0309	Telephone	(855) 237-6178
HEALTHCARE SERVICES DEPARTMENT		
Healthcare Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes Prior Authorizations/ Service Requests. The Healthcare Services (HCS) department also performs Care Management for Members who will benefit from Care Management services. Participating Providers are required to interact with Molina Dual Options' HCS department electronically whenever possible. Prior Authorizations/ Service Requests and status checks can be easily managed electronically. Managing Prior Authorizations/ Service Requests electronically provides many benefits to Providers, such as: • Easy to access 24/7 online submission and status checks. • Ensures HIPAA compliance. • Ability to receive real-time authorization status. • Ability to upload medical records. • Increased efficiencies through reduced telephonic interactions. • Reduces cost associated with ax and telephonic interactions. Continue...	Telephone	(855) 237-6178
	Fax	(866) 423-3889

Molina Dual Options offers the following electronic Prior Authorizations/Service Requests submission options: • Submit requests directly to Molina Dual Options via the Provider Portal. See the Provider Portal Quick Reference Guide or contact your Provider Services representative for registration and submission guidance • Submit requests via 278 transactions. See the EDI transaction section of Molina Dual Options' website for guidance		
HEALTH MANAGEMENT		
Molina Dual Options' Health Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs.	Telephone	(855) 735-5831
BEHAVIORAL HEALTH		
Molina Dual Options manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us directly, 24 hours per day, 365 days per year.	Telephone	(888) 275-8750
PHARMACY DEPARTMENT		
A list of in-network pharmacies are available on the MolinaHealthcare.com website or by contacting Molina Dual Options.	Telephone	(800) 665-3086

III. Eligibility and Enrollment in Molina Dual Options Plan A Medicare-Medicaid Plan

Enrollment Information

A. Members who wish to enroll in Molina Dual Options must meet the following eligibility criteria:

- Have both Medicare Part A and enrolled in Medicare Part B;
- Permanently reside in Molina Dual Options' geographic service area;
- Not be medically determined to have End-Stage Renal Disease (ESRD) prior to completing the enrollment form (unless individual is an existing Molina Medicaid Member);
- Member or Member's legal representative completes an enrollment election form completely and accurately;
- Is fully informed and agrees to abide by the rules of Molina Dual Options;
- The Member makes a valid enrollment request that is received by the plan during an election period; and,
- For Dual Eligible Special Needs Plans: Is entitled to Medicaid benefits as defined by the State of South Carolina.

Furthermore, Molina Dual Options does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

B. Member Toll-Free Telephone Numbers

Existing Members may call Member Services toll-free at (855) 735-5831, TTY/TDD: 711, 7 days a week from 8 a.m. to 8 p.m., local time with questions.

C. Effective Date of Coverage

Molina Dual Options will determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determined when the complete enrollment is signed, received, following the Member's enrollment election period.

D. Disenrollment

Staff of Molina Dual Options may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare MMP Member to disenroll except when the Member has:

- A change in residence (includes incarceration – see below) makes the individual ineligible to remain enrolled in the MMP;
- The Member loses entitlement to either Medicare Part A or Part B;
- The Member loses Medicaid eligibility;
- The Member dies;
- The Member materially misrepresents information to the MMP regarding reimbursement for third-party coverage.

When Members permanently move out of Molina Dual Options service area or leave Molina Dual Options service area for over six consecutive months, they must disenroll from Molina Dual Options. There are a number of ways that the Molina Dual Options Enrollment Accounting department may be informed that the Member has relocated:

- Out-of-area notification will be received from SCDHHS and forwarded to CMS on the monthly membership report;
- Through the CMS DTRR file (confirms that the Member has disenrolled);
- The Member may call to advise Molina Dual Options that they have relocated; and Molina Dual Options will direct them to SCDHHS for formal notification; and/or
- Other means of notification may be made through the Claims department, if out-of-area Claims are received with a residential address other than the one on file; Molina Dual Options will inform SCDHHS so they can reach out to the Member directly to begin the disenrollment process. (Molina Dual Options does not offer a visitor/traveler program to Members).

E. Requested Disenrollment

Molina Dual Options will refer the Member to SCDHHS (or their designated vendor) to process disenrollment of Members from the health plan only as allowed by CMS regulations. Molina Dual Options may request that a Member be disenrolled under the following circumstances:

- Member requests disenrollment;
- Member enrolls in another plan;
- Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan Members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Other reasons for the disenrollment may be one of the following (where Molina Dual Options will notify SCDHHS to begin the disenrollment process):

- Member abuses the enrollment card by allowing others to use it to fraudulently obtain services;
- Member leaves the service area and directly notifies Molina Dual Options of the permanent change of residence;
- Member has not permanently moved but has been out of the service area for six months or more;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina Dual Options loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina Dual Options will send CMS approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or,

- Molina Dual Options discontinues offering services in specific service areas where the Member resides.

In all circumstances except death, (where SCDHHS delegates) Molina Dual Options will provide a written notice to the Member with an explanation of the reason for the disenrollment; otherwise SCDHHS (or its designated enrollment vendor) will provide a written notice. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

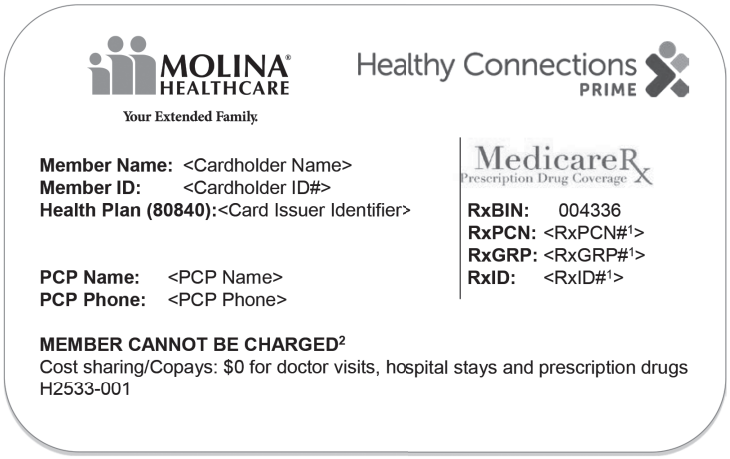
In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Providers and/or Members may contact Member Services at (855) 735-5831, TTY: 711, 7 days a week from 8 a.m. to 8 p.m. local time to discuss enrollment and disenrollment processes and options.

F. Member Identification Card Example – Medical Services

Molina Dual Options

Front of Model Member Identification Card


MOLINA HEALTHCARE
Your Extended Family.

Healthy Connections PRIME

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
Health Plan (80840):<Card Issuer Identifier>

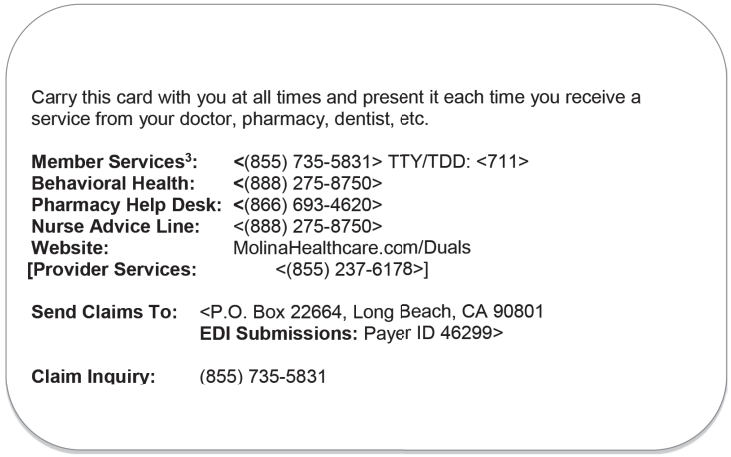
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

MedicareRx
Prescription Drug Coverage

RxBIN: 004336
RxPCN: <RxPCN#[1]>
RxGRP: <RxGRP#[1]>
RxID: <RxID#[1]>

MEMBER CANNOT BE CHARGED[2]
Cost sharing/Copays: $0 for doctor visits, hospital stays and prescription drugs
H2533-001

Back of Model Member Identification Card


Carry this card with you at all times and present it each time you receive a service from your doctor, pharmacy, dentist, etc.

Member Services[3]: <(855) 735-5831> TTY/TDD: <711>
Behavioral Health: <(888) 275-8750>
Pharmacy Help Desk: <(866) 693-4620>
Nurse Advice Line: <(888) 275-8750>
Website: MolinaHealthcare.com/Duals
[Provider Services: <(855) 237-6178>]

Send Claims To: <P.O. Box 22664, Long Beach, CA 90801
EDI Submissions: Payer ID 46299>

Claim Inquiry: (855) 735-5831

G. Verifying Eligibility

Verification of Membership and eligibility status is necessary to ensure payment for health care services being rendered by the Provider to the Member. Molina Dual Options strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of the ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Practitioner/Provider to verify the eligibility of the cardholder.

To verify eligibility, Providers may call Provider Services at (855) 237-6178, TTY: 711 from 8 a.m. to 8 p.m. local time Monday through Friday or visit https://provider.molinahealthcare.com/provider/login.

IV. Benefit Overview

Questions about Molina Dual Options Benefits

If there are questions as to whether a service is covered or requires prior authorization, please contact Molina Dual Options' Member & Provider Services departments toll-free at the numbers below:

Member Services: (855) 735-5831, TTY: 711
7 days a week, 8 a.m. to 8 p.m., local time
Provider Services: (855) 237-6178
Monday - Friday, 8 a.m. to 8 p.m., local time

Link to Summary of Benefits

The following web link provides the Summary of Benefits for the Molina Dual Options Plan in South Carolina: https://www.molinahealthcare.com/members/sc/en-us/mem/duals/plan-materials.aspx

Link to Member Handbook

Detailed information about benefits and services can be found in the Member Handbook provided to each Molina Dual Options Member.

The following web link provides the Member Handbook for Molina Dual Options in South Carolina: https://www.molinahealthcare.com/members/sc/en-us/mem/duals/plan-materials.aspx

Please note: The Medicare-covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. Our plans cover Medicare-covered preventive services at no cost to the Member.

Obtaining Access to Certain Covered Services

Telehealth and Telemedicine Services

Molina Dual Options Members may obtain covered services by participating Providers, through the use of telehealth and telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing covered services, and not a separate benefit.
- Services are not permitted when the Member and participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.
- Covered services provided through store-and-forward technology, must include an in-person office visit to determine diagnosis or treatment.

Upon at least 10 days prior notice to Provider, Molina Dual Options shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina Dual Options. Provider shall make its personnel reasonably available to answer questions from Molina Dual Options regarding telehealth operations.

For additional information on telehealth and telemedicine claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

Supplemental Services

Molina Dual Options offers the following supplemental services benefits.

Services are only available when provided by contracted in-network Providers.

A referral from the Member's PCP is not required for these benefits. To find an in-network Provider, please call the applicable Vendor directly.

HEARING		
HearUSA	Telephone	Toll Free Phone (855) 823-4632, TTY: 711
VISION		
March Vision Care 6701 Center Drive W Suite 790 PO Box 7777 Los Angeles, CA 90045	Telephone	Toll Free Phone (844) 946-2724

TRANSPORTATION (Logisticare)		
Transportation is available for doctor appointments, dialysis, x-rays, lab work, drug store or other non-emergency medical appointments for Molina Dual Options members. If a member needs a ride, they can call the Healthy Connections transportation broker between 8 a.m. and 5 p.m., local time. A ride must be requested at least three days before their appointment. If a member needs to cancel a ride, they must call at least 24 hours in advance. Members may schedule or cancel a ride by calling one of the following toll-free numbers. They can also call Member Services for assistance.	Toll-Free Phone Numbers:	(866) 910-7688 (866) 445-6860 (866) 445-9954
	For more information on LogistiCare, visit	http://memberinfo.logisticare.com/scmember

V. Quality Improvement

Maintaining Quality Improvement Processes and Programs

Molina Dual Options works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Dual Options Quality department toll free at (855) 735-5831.

The address for mail requests is:

Molina Dual Options Medicare-Medicaid Plan
Quality Improvement Department
PO Box 40309
North Charleston, SC 29423-0309

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

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

Molina Dual Options does not delegate Quality Improvement activities to Medical Groups/ Independent Practice Association (IPAs) or delegated entities. However, Molina Dual Options requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. Molina Dual Options Medical Groups/IPAs must:

- Have a quality improvement program in place.
- Comply with and participate in Molina Dual Options' Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Molina Dual Options' Quality Improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina Dual Options to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina Dual Options Quality personnel for site and medical record keeping and documentation practices.

Patient Safety Program

Molina Dual Options' Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Dual Options Plan Members in collaboration with their PCPs. Molina Dual Options continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and care management/disease management programs and education.

Molina Dual Options monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of "never events" among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

Quality of Care

Molina Dual Options has established a systematic process to identify, investigate, review, and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting Member care. Molina Dual Options will research, resolve, track, and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

Molina Dual Options is not required to pay for inpatient care related to "never events".

Medical Records

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

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

Medical Record Keeping Practices

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

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

1. Content

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

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.

- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report.
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

2. Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file; and
- Chart sections are easily recognized for retrieval of information.

A release document for each Member authorizing Molina Dual Options to release medical information for facilitation of medical care.

3. Retrieval

- The medical record is available to Provider at each encounter.
- The medical record is available to Molina Dual Options for purposes of Quality Improvement.

- The medical record is available to the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request.
- A storage system for inactive member medical records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than 10 years; and
- An established and functional data recovery procedure in the event of data loss.

4. Confidentiality

Molina Dual Options Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Dual Options Quality Improvement department. For additional information regarding HIPAA, please see the Compliance section of this Provider Manual.

Access to Care

Molina Dual Options maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs and participating specialists (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 90% availability for Emergency Services and 90% or greater for all other services. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

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

Category	Type of Care	Access Standard
Primary Care Provider (General Practitioners, Internist, Family Practitioners, Pediatricians)	Preventive/Routine Care/Non-Symptomatic	Within 30 calendar days
	Non-Urgent "Sick" Visits	48-72 hours, as clinically indicated
	Urgent Care/Symptomatic Office Visits	Within 24 hours
	Emergent Care	Immediately upon presentation
	After Hours	Available by phone 24 hours a day/ 7 days a week
Specialist	Routine Visits	Within 2 - 4 weeks
Behavioral Health	Initial Routine Care Visit	Within 10 calendar days
	Follow-up Routine Care Visit	Within 30 calendar days
	Urgent Care/Symptomatic Office Visits	Within 24 hours
	Non-Life Threatening Emergency	Within 6 hours
Behavioral Health	Post ER or hospital discharge for behavioral health or substance abuse follow-up care	Within 5 days or as clinically indicated
	Non-urgent mental health or substance abuse visits	Within 2 weeks of request
	Non-Urgent "Sick" Visits	48-72 hours, as clinically indicated
All	Office Wait Time	Maximum of 45 minutes

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

Office Wait Time - For scheduled appointments, the wait time in offices should not exceed **forty-five** minutes from appointment time until the time seen by the PCP. All PCPs are required to monitor waiting times and to adhere to this standard.

After Hours - All providers must have back-up (on call) coverage after hours or during the provider's absence or unavailability. Molina Dual Options requires Primary Care Providers to maintain a 24 hour telephone service, seven days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang-up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

Women's Health Access

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

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

Monitoring Access for Compliance with Standards - Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

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

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites

Molina Dual Options Providers are to maintain office-site and medical record keeping practices standards. Molina Dual Options continually monitors Member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Molina Dual Options assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

Physical Accessibility

Molina evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space

During the site visit as required, Molina Dual Options assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration and Confidentiality of Facilities

Facilities contracted with Molina Dual Options must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with ten or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas.

- Record rooms and/or file cabinets are preferably locked. A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)

Molina Dual Options complies with the advance directive requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents. Advance Directives are a written choice for health care. There are three types of Advance Directives:

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions.
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Guardian Appointment:** allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

Durable Power of Attorney for Health Care: This Advance Directive names another person to make medical decisions on behalf of the Member when they cannot make the choices for themselves. It can include plans about the care a Member wants or does not want and includes information concerning artificial life-support machines and organ donations. This form must be signed, dated, and witnessed by a notary public to be valid.

Directive to Physicians (Living Will): This Advance Directive usually states that the Member wants to die naturally without life-prolonging care and can also include information about any desired medical care. The form would be used if the Member could not speak and death would occur soon. This directive must be signed, dated, and witnessed by two people who know the Member well but are not relatives, possible heirs, or health care Providers.

When There Is No Advance Directive: The Member's family and provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Dual Options Members of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook and other

Member communications such as newsletters and the Molina Dual Options website. If a Member is incapacitated at the time of enrollment, Molina Dual Options will provide advance directive information to the Member's family or representative and will follow up with information to the Member at the appropriate time. All current Members will receive an annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at http://www.caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina Dual Options website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss Advance Directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

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

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

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

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

Monitoring for Compliance with Standards

Molina Dual Options monitors compliance with the established performance standards as outlined above at least annually. Within 30 calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina Dual Options' standards may result in a Corrective Action Plan (CAP) with a request that the Provider submit a written corrective action plan to Molina Dual Options within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

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

Clinical Practice Guidelines

Molina Dual Options adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriate established authority. Please refer to MolinaHealthcare.com/Duals for a current list of CPGs. Clinical Practice Guidelines are reviewed at least annually, and more frequently as needed, when clinical evidence changes and approved by the Quality Improvement Committee.

Individual Providers or Members may request copies by calling Member Services.

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

Preventive Health Guidelines (PHG)

Molina Dual Options provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), and Centers for Disease Control and Prevention (CDC). Diagnostic preventive procedures include, but are not limited to:

- Care for adults 65 years and older
- Immunization schedules for adults

Please refer to MolinaHealthcare.com/Duals for a current list of PHGs.

All guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Dual Options Provider Newsletter.

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Providers and Systems (CAHPS®)

- Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Molina Dual Options evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

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

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

Healthcare Effectiveness Data and Information Set (HEDIS®) - Molina Dual Options utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data.

All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for many of Molina Dual Options' clinical quality activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) - CAHPS® is the tool used by Molina Dual Options to summarize Member satisfaction with the Providers, health care, and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care and Getting Needed Prescription Drugs. The CAHPS® survey is administered annually in the spring to randomly selected Members by a NCQA-certified vendor.

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

Medicare Health Outcomes Survey (HOS) - The HOS measures Medicare Members' physical and mental health status over a two year period and categorizes the two year change scores as better, same, or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

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

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

In addition to the methods described above, Molina also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed.
- Check that staff is properly coding all services provided.
- Be sure patients understand what they need to do.

Molina Dual Options has additional resources to assist Providers and their patients. For access to tools that can assist, please go to the Provider Portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Dual Options Quality department.

Merit-based Incentive Payment System (MIPS)

Under the Medicare Access and CHIP Reauthorization Act (MACRA), CMS implemented the Quality Payment Program Merit-based Incentive Payment System (MIPS). This is a quality payment program that eligible Providers under original Medicare will participate in and does not impact how Medicare Advantage and MMP plans are required to pay. Due to this being a quality program, Providers will not receive a bonus or a withhold for the Quality Payment Program Merit-based Incentive Payment System (MIPS), unless it is specifically in the agreement you have with Molina Dual Options. Please contact your Provider Services Representatives for other quality programs Molina Dual Options offers.

VI. Compliance

Fraud, Waste and Abuse Program

Introduction

Molina Dual Options is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina Dual Options' Compliance department maintains a comprehensive plan, which addresses how Molina Dual Options will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. The plan also addresses fraud, waste, and abuse prevention and detection, along with the education of appropriate employees, vendors, Providers and associates doing business with Molina.

Molina Dual Options' Special Investigation Unit (SIU) supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and report findings to the appropriate regulatory and/or law enforcement agency.

Mission Statement

Molina Dual Options 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 has therefore implemented a plan to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

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

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

- Has actual knowledge of falsity of information in the Claim;

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

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

Deficit Reduction Act

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

As a contractor doing business with Molina Dual Options, Providers and their staff have the same obligation to report any actual or suspected violation of funds by fraud, waste, or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

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

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

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

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

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

Anti-Kickback Statute - Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other federal health care programs.

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

Sarbanes-Oxley Act of 2002 - Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: Means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

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

Abuse: Means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the State and Federal health care programs, or in reimbursement for services that are not Medically Necessary or that failed to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the State and Federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

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

- A Provider knowingly and willfully referring Members to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Member for covered services. This includes asking the Member to pay the difference between the discounted fees, negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.

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

Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the member's benefits.
- Conspiracy to defraud State and Federal health care programs
- Doctor shopping, which occurs when a Member consults a number of providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from, and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina Dual Options 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 performed as authorized.

Molina Dual Options performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste and Abuse Detection Activities

Through implementation of Claims edits, Molina Dual Options' Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Molina Dual Options has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS), Federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit table (MUE), the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/ National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Molina Dual Options may, at the request of a State program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

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

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

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

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

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

Claim Auditing

Molina Dual Options shall use established industry Claims adjudication and/or clinical practices, State and Federal guidelines, and/or Molina Dual Options policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Molina Dual Options' right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina Dual Options' Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina Dual Options' request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina Dual Options may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina Dual Options paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/ regulatory investigation and/or compliance reviews and may be vendor assisted. Molina Dual Options asks that you provide Molina Dual Options, or Molina Dual Options' designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina Dual Options' Special Investigations Unit suspects that there is fraudulent or abusive activity, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

When Molina Dual Options identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Molina Dual Options may determine that a Provider education visit is appropriate.

Molina Dual Options will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Molina Dual Options addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Dual Options 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 Dual Options 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 Dual Options' AlertLine can be reached toll free at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com

You may also report cases of fraud, waste, or abuse to Molina Dual Options' Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Dual Options Medicare-Medicaid Plan
Attn: Compliance
PO Box 40309
North Charleston, SC 29423-0309

Remember to include the following information when reporting:

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

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

South Carolina Department of Health and Human Services

Fraud and Abuse Hotline
Toll Free Phone: (888) 364-3224
By Email: fraudres@scdhhs.gov

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Molina Dual Options Commitment to Patient Privacy

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

Provider Responsibilities

Molina Dual Options expects that its contracted Providers will respect the privacy of Molina Dual Options Members (including Molina Dual Options Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI. Molina Dual Options provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina Dual Options uses and discloses their PHI and includes a summary of how Molina Dual Options safeguards their PHI.

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

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

Applicable Laws

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

1. **Federal Laws and Regulations**

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

2. **State Medical Privacy Laws and Regulations –** Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in the event state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

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

Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity. (See, Sections 164.506 to the (2) & (3) of the HIPAA Privacy Rule.) Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services." (See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule).

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

- Quality Improvement
- Disease Management
- Case Management and Care Coordination
- Training programs
- Accreditation, licensing, and credentialing

Importantly, this allows providers to share PHI with Molina Dual Options for our health care operations activities, such as HEDIS® and quality improvement.

Confidentiality of Substance Use Disorder Patient Records

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

Inadvertent Disclosures of PHI

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

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 Dual Options Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices** – Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
2. **Requests for Restrictions on Uses and Disclosures of PHI** – Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
3. **Requests for Confidential Communications** – Patients may request that a health care Providers communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
4. **Requests for Patient Access to PHI** – Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
5. **Request to Amend PHI** – Patients have a right to request that the Provider amend information in their designated record set.
6. **Request Accounting of PHI Disclosures** – Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

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

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

HIPAA Transactions and Code Sets

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

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

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

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

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina Dual Options 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 Dual Options within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and encounters (both electronic and paper formats) submitted to Molina Dual Options.

Additional Requirements for Delegated Providers Entities

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

Reimbursement for Copies of PHI

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

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

Nonpublic Information Cybersecurity Attachment

Note: This section (Nonpublic Information Cybersecurity Attachment) is only applicable to providers who are a delegated provider and delegated a health plan function.

1. Provider shall comply with the following requirements and permit Molina Dual Options to audit such compliance as required by law or any regulatory agency.
2. Provider shall implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information that are accessible to, or held by, the provider.

Definitions:

i. **"Cybersecurity Event"** means an event resulting in unauthorized access to or the disruption or misuse of an Information System or information stored on an Information System. The term "Cybersecurity Event" does not include the unauthorized acquisition of encrypted Nonpublic Information if the encryption, process, or key is not also acquired, released, or used without authorization. The term "Cybersecurity Event" also does not include an event with regard to which provider has determined that the Nonpublic Information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

ii. **"Information Systems"** means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of electronic information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

iii. **"Nonpublic Information"** means information that is not publicly available information and is:

   a. business related information of Molina the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Molina;

   b. any information concerning a consumer which because of name, number, personal mark, or other identifier can be used to identify such consumer, in combination with any one or more of the following data elements:

      i. social security number;
      ii. driver's license number or non-driver identification card number;
      iii. account number, credit, or debit card number;
      iv. security code, access code, or password that would permit access to a consumer's financial account; or
      v. biometric records.

   c. any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer and that relates to:

      i. the past, present, or future physical, mental or behavioral health or condition of a consumer or a Member of the consumer's family;
      ii. the provision of health care to a consumer; or
      iii. payment for the provision of health care to a consumer.

3. Molina Dual Options agrees to comply with all applicable laws governing Cybersecurity Events, including notification requirements. Molina Dual Options will decide on further action including, but not limited to, notification to affected individuals or government entities. Upon Molina Dual

Options' prior written request, provider agrees to assume responsibility for informing all such individuals in accordance with applicable law.

4. In the event of a Cybersecurity Event, provider shall notify Molina Dual Options' Chief Information Security Officer of such Cybersecurity Event by telephone and email as provided below (with follow-up notification by mail) as promptly as possible, but in no event later than 72 hours from a determination that a Cybersecurity Event has occurred.

   Notification to Molina Dual Options' Chief Information Security Officer shall be provided to:
   Molina Chief Information Security Officer
   Telephone: (844) 821-1942
   Email: CyberIncidentReporting@MolinaHealthcare.com

   Molina Chief Information Security Officer
   Molina Healthcare, Inc.
   200 Oceangate Blvd., Suite 100
   Long Beach, CA 90802

5. Further, in the event of a Cybersecurity Event, provider must provide Molina Dual Options any documentation required by Molina Dual Options to complete an investigation, or, upon written request by Molina Dual Options, complete an investigation pursuant to the following requirements:

   - determine whether a Cybersecurity Event occurred;
   - assess the nature and scope of the Cybersecurity Event;
   - identify Nonpublic Information that may have been involved in the Cybersecurity Event; and
   - perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Nonpublic Information in Molina Dual Options or provider's possession, custody, or control.

6. Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon demand of Molina Dual Options.

7. Provider must provide Molina Dual Options the required information in electronic form as directed by Molina Dual Options. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina Dual Options concerning the Cybersecurity Event. The information provided to Molina Dual Options must include at least the following:

   a. the date of the Cybersecurity Event;
   b. a description of how the information was exposed, lost, stolen, or breached, including the specific roles and responsibilities of provider, if any;
   c. how the Cybersecurity Event was discovered;

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

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

f. whether provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;

g. a description of the specific types of information acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;

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

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

j. the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

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

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

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

VII. Health Care Services (HCS)

Introduction

Healthcare Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina Dual Options provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina Dual Options utilization management program include pre-service authorization request/organization determination and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review, and restrictions on the use of out of network Providers.

Utilization Management (UM)

Molina Dual Options ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes in the Member's condition and is designed to influence Member's care by:

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

Key Functions of the UM Program

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

Eligibility and Oversight	Resource Management	Quality Management
Eligibility verification	Prior Authorization and Referral Management	Satisfaction evaluation of the UM program using Member and Provider input
Benefit administration and interpretation	Pre-admission, Admission and Inpatient Review	Utilization data analysis
Ensure authorized care correlates to Member's medical necessity need(s) & benefit plan	Post service/post claim audits	Monitor for possible over- or under-utilization of clinical resources
Verifying current physician/ hospital contract status	Referrals for Discharge Planning and Care Transitions	Quality oversight
Delegation oversight	Staff education on consistent application of UM functions	Monitor for adherence to CMS, NCQA, State and health plan UM standards

This Molina Dual Options Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your State's Healthcare Services Program Description contact the UM Department to receive a written copy. You can always find more information about Molina Dual Options' UM program, including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina Dual Options website or by calling the UM department.

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

Medical Necessity Review

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

Clinical Information

Molina Dual Options requires copies of clinical information be submitted for documentation in all medical necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina Dual Options does not accept clinical summaries; telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior Authorization

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

Request for prior authorization may be sent by telephone, fax, mail, or via the Provider Portal.

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

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

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon medical necessity and member eligibility at the time of service.

Molina Dual Options makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, health or safety of the Member or others,

due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determination/pre-service authorization requests, we make a determination as promptly as the Member's health requires and no later than 72 hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina Dual Options makes the determination and provides notification within 14 calendar days.

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 Dual Options has a full-time Medical Director available to discuss medical necessity decisions through Molina Dual Options' peer-to-peer process.

Upon approval, the requestor will receive an authorization reference number. The number may be provided by telephone or fax. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails.

Molina Dual Options abides by CMS rules and regulations for all organization determinations/ pre-service authorization requests and will allow a peer-to-peer conversation in limited circumstances.

- While the request is being reviewed, but prior to a final determination being rendered.
- While an appeal of an Organizational Determination/pre-service authorization request is being reviewed.
- Before a determination has been made. If the Molina Dual Options Medical Director believes that a discussion with the requesting physician would assist Molina Dual Options in reaching a favorable determination (within the obligatory timeframes stated above for a standard or expedited request).

Medicare says that if Molina Dual Options, being a Medicare Advantage plan, decides to not provide or pay for a requested service, in whole or in part, then an adverse Organization Determination (denial) has occurred and we must issue a written denial notice. Once the notice has been mailed or faxed to you, or the Member, or Molina Dual Options has phoned the Member and/or you, advising that there has been an adverse Organization Determination (denial), the appeals process then becomes available to you.

If you wish to dispute Molina Dual Options' adverse Organization Determination (denial) we may only process the request by following the Standard or Expedited appeal process. This means

that if you contact Molina Dual Options to request a Peer-to-Peer review, we will advise you that you must follow the rules for requesting a Medicare appeal. Refer to the Member Grievances and Appeals section of this Provider Manual.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Molina Dual Options, Molina Dual Options may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the MolinaHealthcare.com/Duals website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix
- Prior Authorization Guide

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

Provider Portal: Participating Providers are encouraged to use the Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

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

Provider Portal: https://provider.MolinaHealthcare.com

Fax: The Prior Authorization Request Form can be faxed to Molina Dual Options at:
(866) 423-3889

Phone: Prior authorizations can be initiated by contacting Molina Dual Options' Healthcare Services department at (855) 237-6178. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:
Molina Healthcare of South Carolina
Attn: Healthcare Services Dept.
PO Box 40309
North Charleston, SC 29423-0309

Affirmative Statement about Incentives

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

Molina Dual Options requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. Molina Dual Options does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. And, Molina Dual Options does not receive financial incentives or other types of compensation to encourage decisions that result in under-utilization.

Open Communication about Treatment

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

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

Clinical Trials

For information on clinical trials, go to cms.hhs.gov or call (800) MEDICARE.

Information Only: On September 19, 2000, the Health Care Financing Administration (HCFA) approved a National Coverage Policy that permits all Medicare Beneficiaries to participate in qualified clinical trials. For the initial implementation, Medicare will pay providers and hospitals directly on a fee-for-service basis for covered clinical trial services for members of Molina's Medicare plans and other Medicare HMO plans. The provider and/or hospital conducting the clinical trial will submit all Claims for clinical trial services directly to Medicare, not to the Medicare plan. This means the member will be responsible for all Medicare fee for service deductibles and co-payments for any services received as a participant in a clinical trial.

Delegated Utilization Management Functions

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

Communication and Availability to Members and Providers:

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 237-6178 during normal business hours, Monday through Friday (except for holidays) from 8 a.m. to 5 p.m. All staff Members identify themselves by providing their first name, job title, and organization.

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

After business hours, Providers can also utilize fax and the Provider Portal for UM access. Molina Dual Options' Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (888) 275-8750. Molina Dual Options' Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Levels of Administrative and Clinical Review

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

All UM requests that may lead to a denial are reviewed by a health care professional at Molina Dual Options (medical director, pharmacy director, or appropriately licensed health professional).

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

Emergency Services

Emergency Services means covered inpatient and outpatient services furnished by a Provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

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

Members over-utilizing the emergency department will be contacted by Molina Dual Options Care Coordinators to provide assistance whenever possible and determine the reason for using Emergency Services.

Care Coordinators will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

Molina Dual Options requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina Dual Options requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting notification, medical necessity requirements, or failure to include all of the needed clinical documentation to support the inpatient admission will result in a denial of authorization for the inpatient stay.

Post service medical necessity review is performed when:

- Information is received indicating the Provider did not know, or reasonably could not have known that the patient was a Molina Dual Options Member.
- There was a Molina Dual Options clerical error.

Prospective/Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests. Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Area/Out-of-Network Professional Services. The pre-service review process assures the following:

- Member eligibility.
- Member covered benefits.
- The service is not experimental or investigational in nature.
- The service meets Medical Necessity criteria (according to accepted, nationally-recognized resources).
- All Covered Services, (e.g., test, procedure) are within the Provider's scope of practice.
- The requested Provider can provide the service in a timely manner.
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition.

- The requested Covered Service is directed to the most appropriate contracted specialist, facility or vendor.
- The service is provided at the appropriate level of care in the appropriate facility; e.g., outpatient versus inpatient or at appropriate level of inpatient care.
- Continuity and coordination of care is maintained.
- The PCP is kept apprised of service requests and of the service provided to the Member by other Providers.

Inpatient/Concurrent Review

Molina Dual Options performs concurrent inpatient review to ensure medical necessity and appropriateness of an inpatient stay. The goal of inpatient review is to authorize care, identify appropriate discharge planning needs and facilitate discharge to an appropriate setting. The criteria used to determine medical necessity will be as described in "Medical Necessity Review."

The inpatient review process assures the following:

- Members are correctly assigned to observation or inpatient status.
- Services are timely and efficient.
- Comprehensive treatment plan is established.
- Member is not being discharged prematurely.
- Member is transferred to appropriate in-network hospital or alternate levels of care when clinically indicated.
- Effective discharge planning is implemented.
- Member appropriate for outpatient case management is identified and referred.

Molina Dual Options follows payment guidelines for inpatient status determinations consistent with CMS guidelines, including the two midnight and observation rules as outlined in the Medicare Benefit Policy Manual.

NOTICE Act

Under the NOTICE Act, hospitals and CAHs must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA member) who receives observation services as an outpatient for more than 24 hours. See the final rule that went on display August 2, 2016 (published August 22, 2016) at: https://www.federalregister.gov/documents/2016/08/22/2016-18476/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the

Inpatient Status Determinations

Molina Dual Options' UM staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Inpatient Facility Admission

Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Proper notification is required by Molina Dual Options on the day of admission to ensure timely and accurate payment of hospital claims. Delegated Medical Groups/IPAs must have a clearly defined process that requires the hospital to notify Molina Dual Options on a daily basis of all hospital admissions.

Notifications may be submitted by fax. Contact telephone numbers and fax numbers are noted in the introduction to the Healthcare Services section of this Provider Manual.

Discharge Planning

Discharge planning involves a process of communicating with hospitals and Practitioners to ensure that a Member's needs are met upon hospital discharge, and that the discharge occurs in a timely manner.

The clinical staff is responsible for collaborating with hospital discharge planning to facilitate an appropriate discharge plan for the Member. The clinical staff reviews the medical necessity and appropriateness for select post discharge services including home health, infusion therapy, durable medical equipment, skilled nursing facility and rehabilitative services.

Post discharge follow-up letters are sent to all Members and their PCPs after an inpatient admission.

Members with certain conditions may receive up to 30 days of post discharge support from Care Transition staff.

Readmissions

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

Molina Dual Options will conduct readmission reviews for participating hospitals when both admissions occur at the same acute inpatient facility within the State regulatory requirement dates. There are two situations for Readmissions: Readmissions occurring within 24 hours from discharge (same or similar diagnosis); and Readmissions occurring within 2-30 days of discharge (same or similar PLUS preventable).

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

A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:

- Premature or inadequate discharge from the same hospital.
- Issues with transition or coordination of care from the initial admission.
- For an acute medical complication plausibly related to care that occurred during the initial admission.
- Readmissions that are excluded from consideration as preventable readmissions include:
    - Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
    - Transplant related admissions.
    - Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.

Out-of-Network Providers and Services

Molina Dual Options maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Molina Members. Molina Dual Options requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Molina Dual Options. Non-network Providers may provide Emergency Services for a Member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

"Emergency Services" means covered inpatient and outpatient services furnished by a Provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

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

Coordination of Care and Services

Molina Dual Options HCS Staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina Dual Options' Integrated Care Management (ICM) program via assessment or referral such as self-referral, Provider referral, etc. In addition, the coordination of care process assists Molina Dual Options Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Dual Options Members whose benefits are ending and are in need of continued care.

Molina Dual Options staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina Dual Options staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state funded agencies.
- Education about alternative care.
- How to obtain care as appropriate.

Continuity of Care and Transition of Members

It is Molina Dual Options' policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition
- Following termination, the terminated Provider will continue to provide covered services to the Member up to 90 days or longer if necessary, for a safe transfer to another Provider as determined by Molina Dual Options or its delegated Medical Group/IPA.

For additional information regarding continuity of care and transition of Members, please contact Molina Dual Options at (855) 237-6178.

Continuity and Coordination of Provider Communication

Molina Dual Options 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.

Peer to Peer Discussions

Upon receipt of an adverse determination, the provider (peer) may request a peer to peer discussion within 3 days of a decision for prior authorization requests. For inpatient admissions, a request for a peer to peer discussion may be granted as long as the Member is still in the facility.

A "peer" is considered a physician, physician assistant, nurse practitioner, or PhD psychologist who is directly providing care to the Member or a Medical Director on site at the facility. Calls from EHR and other similar contracted external parties, administrators, or facility UM staff are not peers and calls will not be returned.

UM Decisions

A decision is any determination (e.g., an approval or denial) made by Molina Dual Options or delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination).
- Determination to deny requests (adverse determination).
- Discontinuation of a service.
- Payment for temporarily out-of-the-area renal dialysis services.
- Payment for Emergency Services, post stabilization care or urgently needed services.
- Payment for any other health service furnished by a Provider that the Member believes is covered under Medicare or if not covered under Medicare, should have been furnished, arranged for or reimbursed by Molina Dual Options Medicare or the delegated Medical Group/IPA or other delegated entity.

Molina Dual Options follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Molina Dual Options covers all services and items required by State and Federal regulations.

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

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

Providers can contact Molina Dual Options' Healthcare Services department at (855) 237-6178 to obtain Molina Dual Options' UM Criteria.

Clinical criteria does not replace Medicare Coverage Determinations when making decisions regarding appropriate medical treatment for Molina Dual Options Members. As a Medicare Plan, Molina Dual Options and its delegated Medical Groups/IPAs, or other delegated entity at a minimum, cover all services and items required by Medicare.

1. **Initial Organization Determinations/Pre-service authorization requests** – A request for expedited determinations may be made. A request is expedited if applying the standard determination timeframes could seriously jeopardize the life or health of the Member or the Member's ability to re-gain maximum function. Molina and any delegated Medical Group/IPA or other delegated entity is responsible to appropriately log and respond to requests for expedited initial organization determinations.
    - Expedited Initial requests must be made as soon as medically necessary, within 72 hours (including weekends and holidays) following receipt of the validated request.

- Standard requests must be made as soon as medically indicated, within a maximum of 14 calendar days after receipt of the request.

Delegated Medical Groups/IPAs or other delegated entities are responsible for submitting a monthly log of all Expedited Initial Determinations to Molina Dual Options' Delegation Oversight Department that lists pertinent information about the expedited determination including Member demographics, data and time of receipt and resolution of the issue, nature of the problem and other information deemed necessary by Molina Dual Options or the Medical Group/IPA or other delegated entities.

2. **Written Notification of Denial** – The Member must be provided with written notice of the determination, if the decision is to deny, in whole or in part, the requested service or payment. If the Member has an authorized representative, the representative must be sent a copy of the denial notice. The appropriate written notice, that has CMS approval, must be issued within established regulatory and certification timelines. The adverse organization determination notice shall be written in a manner that is understandable to the Member and shall provide the following:

   - The specific reason for the denial, including the precise criteria used to make the decision that takes into account the Member's presenting medical condition, disabilities and language requirements, if any.
   - Information regarding the Member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the Member's behalf.
   - Include a description of both the standard and expedited reconsideration process, timeframes and conditions for obtaining an expedited reconsideration, and the other elements of the appeals process.
   - Payment denials shall include a description of the standard reconsideration process, timeframes and other elements of the appeal process.
   - A statement disclosing the Member's right to submit additional evidence in writing or in person.

   Failure to provide the Member with timely notice of an organization determination constitutes an adverse organization determination which may be appealed.

3. **Termination of Provider Services (SNF, HH, CORF)/Issuance of Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC)** – When a termination of authorized coverage of a Member's admission to a skilled nursing facility (SNF), coverage of home health agencies (HHA), or comprehensive outpatient rehabilitation facility (CORF) services occurs, the Member must receive a written notice two calendar days or two visits prior to the proposed termination of services.

   Molina Dual Options or the delegated Medical Group/IPA must coordinate with the SNF, HHA or CORF Provider to ensure timely delivery of the written notice, using the approved NOMNC. All elements of the NOMNC are required and the Member or authorized representative must sign and date the notice to document receipt.

- The NOMNC must include the Member's name, delivery date, date that coverage of services ends and Quality Improvement Organization (QIO) information.
- The NOMNC may be delivered earlier than two days before coverage ends.
- If coverage is expected to be fewer than two days in duration, the NOMNC must be provided at the time of admission.
- If home health services are provided for a period of time exceeding two days, the NOMNC must be provided on or before the second to last service date.

Molina Dual Options (or the delegated entity) remains liable for continued services until two days after the Member receives valid notice. If the Member does not agree that covered services should end, the Member may request a Fast Track Appeal by the Quality Improvement Organization (QIO) by noon of the day following receipt of the NOMNC, or by noon of the day before coverage ends.

Upon notification of the Member's request for the fast track, a delivery of the notice is not valid unless appeal. Molina Dual Options (or the delegated entity) must provide a detailed notice to the Member and to the QIO no later than the close of business, using the approved DENC explaining why services are no longer necessary or covered. The DENC must include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered.
- A description of any applicable coverage rule, instruction or other policy, citations, or information about how the Member may obtain a copy of the policy from Molina Dual Options or the delegated entity.
- Any applicable policy, contract provision or rationale upon which the termination decision was based.
- Facts specific to the Member and relevant to the coverage determination that is sufficient to advise the Member of the applicability of the coverage rule or policy to the Member's case.

Reporting of Suspected Abuse and/or Neglect

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

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

- Physicians, dentists, interns, residents, or nurses.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

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

Adult Abuse

South Carolina Department of Social Services (DSS)
Mail: South Carolina Department of Social Services PO Box 1520
Columbia, SC 29202-1520
Phone: (888) 227-3487
Website: dss.sc.gov

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

Molina Dual Options will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina Dual Options will track, analyze, and report aggregate information regarding abuse reporting to the Healthcare Services Committee and the proper State agency.

Emergency Services and Post-Stabilization Services

Emergency Services means covered inpatient and outpatient services furnished by a Provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

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

Molina Dual Options accomplishes this service by providing a 24 hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina contracts with vendors that provide 24 hour Emergency Services for ambulance and hospitals.

Molina Dual Options and its contracted Providers must provide emergency services and post-emergency stabilization and maintenance services to treat any Member with an Emergency Medical Condition in compliance with Federal Law. An Emergency Medical Condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious impairment to bodily functions.

- Serious dysfunction of any body part.
- Serious disfigurement.

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

Pre-approval of emergency services is not required. Molina Dual Options requires the hospital emergency room to contact the Member's primary care Provider upon the Member's arrival at the emergency room. After stabilization of the Member, Molina Dual Options requires pre-approval of further post-stabilization services by a participating Provider or other Molina Dual Options representative. Failure to review and render a decision on the post-stabilization pre-service request within one hour of receipt of the call shall be deemed an authorization of the request.

Molina Dual Options or its delegated entity is financially responsible for these services until Molina Dual Options or its delegated entity becomes involved with managing or directing the Member's care.

Molina Dual Options and its delegated entity provides urgently needed services for Members temporarily outside of the service area but within the United States or who have moved to another service area but are still enrolled with. Urgent Services are covered services that are medically necessary and are needed urgently, typically the same day or within two days of onset of symptoms, as judged by a prudent layperson.

Primary Care Providers

Molina Dual Options provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Molina Dual Options. Molina Dual Options' Medicare Members are required to see a PCP who is part of the Molina Dual Options Medicare Network. Molina Dual Options' Medicare Members may select or change their PCP by contacting Molina Dual Options' Member & Provider Contact Center.

Specialty Providers

Molina Dual Options maintains a network of specialty Providers to care for its Members. Referrals from a Molina Dual Options PCP are required for a Member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

Molina Dual Options will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Molina Dual Options UM department. Referrals to specialty care outside the network require prior authorization from Molina Dual Options.

Care Management (CM)

The Integrated Care Management (ICM) Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Care Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members who have been identified for Molina Dual Options' ICM program. Members may receive health risk assessments that help identify physical health, behavioral health, and medication management problems, and social determinants of health to target high-needs members who would benefit from assistance and education from a case manager. Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs. To initiate the care management process, the Member is screened for appropriateness for ICM program enrollment using specified criteria. Criteria are used for opening and closing cases appropriately with notification to the Member, member authorized representative(s) and/or Provider.

1. The role of the Care Coordinator includes:

    - Coordination of quality and cost-effective services.
    - Appropriate application of benefits.
    - Promotion of early, intensive interventions in the least restrictive setting of the Member's choice.
    - Assistance with transitions between care settings and/or Providers.
    - Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans.
    - Creation of ICPs, updated as the Member's conditions, needs and/or health status change.
    - Facilitation of Interdisciplinary Care Team (ICT) meetings, as needed.
    - Promote Utilization of multidisciplinary clinical, behavioral and rehabilitative services.
    - Referral to and coordination of appropriate resources and support services, including but not limited to Long- Term Services & Supports (LTSS).
    - Attention to Member preference and satisfaction.
    - Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality.
    - Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence.
    - Protection of Member rights.
    - Promotion of Member responsibility and self-management.

2. Referral to Care Management may be made by any of the following entities:

    - Member or Member's designated representative(s)
    - Member's Primary Care Provider.

Specialists

- Hospital Staff
- Home Health Staff
- Molina Dual Options Staff

Special Needs Plan (SNP) Model of Care and 3-Way Contract

The Model of Care is the framework for care management processes and systems that enable coordinated care for our Dual Eligible Special Needs Plan (D-SNP) Members, while the State's 3-way contract guides the coordination for Molina Dual Options Members enrolled under the Medicare-Medicaid Plan (MMP). The Model of Care includes descriptions of SNP population (including health conditions), Care Coordination, Provider Network and Quality Measurement and Performance Improvement.

1. **Targeted Population** – Molina Dual Options operates Medicare Dual Eligible Special Needs Plans (D-SNP) for Members who are eligible for both Medicare and Medicaid. In accordance with CMS regulations, Molina Dual Options has a Model of Care that outlines Molina's efforts to meet the needs of the Members enrolled in D-SNP plans. This population has a higher amount of Members with multiple chronic conditions and sub-populations of frail/disabled Members than other Medicare Managed Care Plan types. The Molina Dual Options Model of Care addresses the needs of all sub-populations found in the Molina Medicare SNP.
2. **Care Management Goals** – Utilization of Molina Dual Options' extensive network of primary Providers, specialty Providers and facilities, in addition to services from the Molina Dual Options ICT, will improve Molina Dual Options Members access to essential services such as physical health, behavioral health and social services. Molina Dual Options demonstrates its compliance with this goal using the following data to see annual improvement compared to benchmarks:
    a. Reports showing availability of services by geographic area;
    b. Number of Members utilizing the following services:
        - Primary Care Provider (PCP) Services
        - Specialty (including Behavioral Health) Services
        - Inpatient Hospital Services
        - Skilled Nursing Facility Services
        - Home Health Services
        - Behavioral Health Facility Services
        - Durable Medical Equipment Services
        - Emergency Department Services
        - Supplemental transportation benefits
        - LTSS
    c. HEDIS® use of services reports
    d. Member Access Complaint Report

e. Medicare CAHPS® Survey
f. Molina Dual Options Provider Access Survey

3. **Access to quality affordable health care.** Molina Dual Options focuses on delivering high quality care. Molina Dual Options has an extensive process for credentialing network Providers, ongoing monitoring of network Providers and peer review for quality of care complaints. Molina Dual Options maintains recommended clinical practice guidelines that are evidence based and nationally recognized. Molina Dual Options regularly measures Provider adherence to key provisions of its clinical practice guidelines. Molina Dual Options demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

   a. HEDIS® report of percent Providers maintaining board certification
   b. Serious reportable adverse events report
   c. Annual report on quality of care complaints and peer reviews
   d. Annual PCP medical record review
   e. Clinical Practice Guideline Measurement Report
   f. Licensure sanction report review
   g. Medicare/Medicaid sanctions report review

4. By having access to Molina Dual Options' network of primary care and specialty Providers as well as Molina Dual Options' programs that include Care Management Service Coordination, Nurse Advice Line, Utilization Management and Quality Improvement, Members have an opportunity to improve health outcomes.

   Molina Dual Options demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks:

   a. Medicare Health Outcomes Survey (HOS)
   b. Chronic Care Improvement Program Reports

5. **Members will have an assigned point of contact for their coordination of care.** According to Member's needs and/or preferences, this coordination of care point of contact may be their Molina Dual Options Network PCP or Molina Care Coordinator. Care will be coordinated through a single point of contact who interact with the ICT to coordinate services and ICP reviews/attestations, as needed.

6. **Improved transitions of care across health care settings, Providers and health services.** Molina Dual Options has programs designed to improve transitions of care. Authorization processes enable Molina staff to become aware of transitions of care as they occur. Molina Dual Options Care Coordinators work with Members, their caregivers, authorized representative(s) and/or their Providers to ensure all are aware of the transition episode, address risk associated with transition needs, and assist with planning, preparation and follow up care post transition. Molina Dual Options' transition of care program provides

follow-up telephone calls or face-to-face visits to Members while the Member is in the hospital, when possible, and/or after hospital discharge to make sure that they received and are following an adequate discharge plan. The purpose is to establish a safe discharge plan, ensure the Members have an understanding on how to manage their condition and are able to follow the prescribed discharge plan once they are home. The Molina Dual Options Care Coordinator will work with the member to ensure they have scheduled a follow up physician appointment, filled all prescriptions, understand how to administer their medications and have received the necessary discharge services such as home health care, durable medical equipment/supplies and/or physical therapy. Molina Dual Options demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement:

a. Transition of Care Data
b. Re-admission within 30 Days Report
c. Provider adherence to notification requirements
d. Provider adherence to provision of the discharge plan

7. **Improved access to preventive health services.** Molina Dual Options expands the Medicare preventive health benefit by providing annual preventive care visits at no cost to all Members. This allows PCPs to coordinate preventive care on a regular basis. Molina Dual Options uses and publicizes nationally recognized preventive health schedules to its Providers. Molina Dual Options also makes outreach calls to Members to remind them of overdue preventive services and to offer assistance with arranging appointments and providing transportation to preventive care appointments.

   Molina Dual Options demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: HEDIS® Preventive Services Reports

8. **Appropriate utilization of health care services.** Molina utilizes its Utilization Management team to review appropriateness of requests for health care services using appropriate Medicare criteria and to assist in Members receiving appropriate health care services in a timely fashion from the proper Provider.

   Molina Dual Options demonstrates its compliance with this goal using the following data and comparing against available internal and external benchmarks and expects to see annual improvement compared to benchmarks: Molina Dual Options Over and Under Utilization Reports.

9. **Staff Structure and Roles** - Molina Dual Options has developed its staff structure and roles to meet the needs of our Members. Molina Dual Options' background as a Provider of Medicaid Managed Care services in the states that it serves allows the plan to have expertise in both the Medicare and Medicaid benefits that Members have access to in Molina Dual Options' D-SNP plan. Molina Dual Options has many years of experience managing this population of patients within Medicaid to go with its experience of managing the Medicare part of their benefit. Molina Dual Options' Member advocacy and

service philosophy is designed and administered to assure Members receive value-added coordination of health care and services that ensures continuity and efficiency and that produces optimal outcomes. Molina Dual Options employed staff are organized in a manner to meet this objective and include:

i. Care Review Processors – Gathers clinical information about transitions in care and authorizations for services, authorize services within their scope of training and job parameters based upon predetermined criteria, serves as a resource for nursing staff in collecting existing clinical information to assist nursing assessments and care team coordination.

ii. Care Review Clinicians (LVN/RN) – Assess, authorize, coordinate, and evaluate services, including those provided by specialists and therapists, in conjunction with the Member, Providers and other team members based on Member's needs, medical necessity and predetermined criteria.

iii. Care Coordinators (comprised of disciplines such as Registered Nurses, Licensed Vocational/practical Nurses, Social Workers, Gerontologists and other health professionals with appropriate background and experience serving vulnerable populations) – Assessing, coordinating, triaging, and evaluating services in conjunction with the Member, Providers and other team members based on Member's assessed needs and preferences. The CM supports Members, caregivers, authorized representative(s) and Providers which may include facilitation of information retrieval from ancillary Providers, consultants, and diagnostic studies for development, implementation and/or revision of the ICP. The CM continues to work with the Member to identify and address issues regarding Member's physical health, behavioral health, LTSS and social needs; and maintains and updates the ICP and assists in the coordination of services. Updates to the ICP are communicated by the CM to the Member, Provider and participants of the ICT based on Member preference.

iv. Health Manager – Serves as a resource for Members and Molina Dual Options staff members regarding Health Management Program information, educates Members on how to manage their condition. Assists Members with addressing physical health, behavioral health, functional and cognitive barriers.

v. Transitions of Care Coach – (Comprised of disciplines such as Registered Nurses, Licensed Vocational/practical Nurses (LVN)/ Licensed Practical Nurses (LPN), Social Workers, Gerontologists and other health professionals with appropriate background and experience serving vulnerable populations)

    - The Transitions Coach functions as a facilitator of interdisciplinary collaboration across the transition, engaging the Member, authorized representative(s) and caregivers, facility and Providers to participate in the formation and implementation of an ICP including interventions to mitigate the risk of re-hospitalization. The primary role of the Transitions staff is to follow the Member closely for up to 30 days post discharge to ensure a safe transition to the least restrictive most inclusive setting of the Member's choice and to encourage self-management and direct communication between the Member and Provider(s).

vi. Community Connectors/Health Workers – the Community Connectors are community health workers who act as *Care CoordinatorExtenders* who assist the member in navigating their healthcare needs and connect them to community-based resources, education, advocacy and social support. Community Connectors are members of the community in which they serve and therefore understand the community's culture, language and norms. They may assist Members with housing, food, clothing, heating, transportation, scheduling appointments, medication refills, obtaining DME and identifying community advocates for eligibility/financial needs.

vii. Behavioral Health Team includes Molina Dual Options employed clinical behavioral health specialists to assist in behavioral health care issues. A board-certified Psychiatrist functions as a Behavioral Health Medical Director and as a resource for the ICM and UM Teams and Providers regarding Member's behavioral health care needs and care plans.

A. Member & Provider Contact Center – Serves as a Member's initial point of contact with Molina Dual Options and main source of information about utilizing the Molina Dual Options benefits and is comprised of the following positions:

i. Member Services Representative – Initial point of contact to answer Member questions, assist with benefit information and interpretation, provide information on rights and responsibilities, assist with PCP selection, advocate on Members' behalf, assist Members with interpretive/translation services, inform and educate Members on available services and benefits, act as liaison in directing calls to other departments when necessary to assist Members.

ii. Member Services Managers/Directors – Provide oversight for Member Services programs, provide and interpret reporting on Member Services functions, evaluate Member Services department functions, identify and address opportunities for improvement

B. Appeals and Grievances Team that assists Members with information about and processing of appeals and grievances:

i. Appeals and Grievances Coordinator – Provide Member with information about appeal and grievance processes, assist Members in processing appeals and grievances, notifies Members of appeals and grievance outcomes in compliance with CMS regulations.

ii. Appeals and Grievances Manager – Provide oversight of appeals and grievance processes assuring that CMS regulations are followed, provide and interpret reporting on A&G functions, evaluate A&G department functions, identify and address opportunities for improvement.

C. Quality Improvement Team that develops, monitors, evaluates, and improves the Molina Dual Options Quality Improvement Program. QI Team is comprised of the following positions:

i. QI Specialist – Coordinate implementation of QI Program, gather information for QI Program reporting and evaluations, provide analysis of QI Program components.

ii. QI Managers/Directors – Development and oversight of QI Program which includes program reporting and evaluation to identify and address opportunities for improvement.

iii. HEDIS® Specialist – Gather and validate data for HEDIS® reporting.

iv. HEDIS® Manager – Oversight and coordination of data gathering and validation for HEDIS® reporting, provide and interpret HEDIS® reports, provide preventive services missing services report.

D. Medical Director Team has employed board-certified physicians.

i. Medical Directors and Healthcare Services Program Manager - Responsible for oversight of the development, training and integrity of Molina Dual Options' Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and Utilization Management Teams and Providers regarding Member's health care needs and care plans. Selects and monitors usage of nationally recognized medical necessity criteria, preventive health guidelines and clinical practice guidelines.

E. Behavioral Health Team has Molina Dual Options employed health specialists to assist in behavioral health care issues:

i. Psychiatrist Medical Director – Responsible for oversight of the development and integrity of behavioral health aspects of Molina's Healthcare Services and Quality Improvement programs. Resource for Integrated Care Management and Utilization Management teams and Providers regarding Member's behavioral health care needs and care plans. Develops and monitors usage of behavioral health related medical necessity criteria and clinical practice guidelines.

F. Pharmacy Team has employed pharmacy professionals that administer the Part D benefit and assist in administration of Part B pharmacy benefits.

i. Pharmacy Technician – Serves as point of contact for Members with questions about medications, pharmacy processes, and pharmacy appeals and grievances.

ii. Pharmacist – Provide authorizations for Part D medications. Provide oversight of pharmacy technician performance, resource for Care Management Teams, other Molina Dual Options staff and Providers, provide review of post discharge medication changes, review Member medication lists and report data to assure adherence and safety, interact with Members and Providers to discuss medication lists and adherence.

G. Healthcare Analytics Team

i. Healthcare Analysts – Assist in gathering information, developing reports, providing analysis for health plan to meet CMS reporting requirements, evaluate the model of care and review operations.

ii. Director Healthcare Analytics – Develop predictive modeling programs used to assist in identifying Members at risk for future utilization, oversight of health care reporting and analysis program, oversight of clinical aspects of Part C Quality Reporting, oversight of health care analysts.

H. Health Management Team is a Molina care team that provides multiple services to Molina Dual Options' Members. This team provides population based Health Management Programs for low risk Members identified with asthma and depression. The Health Management team is comprised of the following positions:

i. Medicare Member Outreach Assistant – Make outbound calls related to gathering and giving information regarding Health Management programs, make outbound calls to review whether Member received hospital discharge plan, make referrals to Care Coordinatorswhen Members have questions about their hospital discharge plan, make outbound preventive service reminder calls.

I. Nurse Advice Line Team – a live Registered Nurse is available to receive inbound calls from Members and Providers with questions about medical care and after-hours issues that need to be addressed, give protocol based medical advice to Members and direct after-hours transitions in care. The Nurse Advice Line is available 24 hours/7 days a week for Members.

J. Interdisciplinary Care Team

i. Composition of the Interdisciplinary Care Team (ICT): ICT participants are determined by Member preferences or identified needs and inclusion decisions are made collaboratively and with respect to the Member's needs and rights to self-direct care, as applicable. Family members and caregiver participation is encouraged and promoted, with the Member's permission. Members are educated about the ICT process during the assessment and provided instruction on how to access an ICT team member and how to request a formal ICT meeting. The CM provides invitations either verbally or in writing to ICT participants and the Member and their PCP are encouraged to participate. The Member may opt out of the ICT meeting and/or choose to limit the role of the participants including caregivers or other Providers.

Collaborators, based on Member preferences and needs may include, but are not limited to:

- Caregiver/Member Representative(s) (if applicable)
- PCP, Nurse Practitioner (NP), Physician Assistant (PA)
- Care CoordinatorMolina Medical Director
- Other Molina staff such as, Social worker, Behavioral Health, Pharmacist, as needed
- Molina Transitions of Care staff
- Hospitalist/Discharge Planner or SNF/Long-Term Acute Care Facility Teams
- Molina Community Connectors
- Specialty Providers
- Home Health Providers
- Behavioral Health Providers
- Care Coordinatorsfrom County Agencies
- Certified Outpatient Rehabilitation Staff

- Behavioral Health Facility Staff
- Renal Dialysis Center Staff
- Out of Network Providers or Facility Staff (until a member's condition or the state of the Molina Dual Options Network allows safe transfer to network care)

ii. ICT Operations and Communication

The Member's assigned PCP and/or the Molina Dual Options Care Coordinator will facilitate and present the majority of the Member's case during the formal ICT meeting. The PCP will regularly (frequency depends on the Member's medical conditions and status) address the Member's medical conditions, develop appropriate treatment plans, request consultations, evaluations and care from other Providers both within and, when necessary, outside the Molina Dual Options Network. The Molina Dual Options Care Coordinator will work with the Member, Member representative(s) and/or Provider(s) in completing assessments, developing the ICP and individualized care goals. The PCP is expected to review the Member's individualized care plan (ICP) at creation and every update thereafter. Molina Dual Options will ensure each Member's PCP has completed the ICP review by tracking and collecting the PCP ICP attestation forms or when consulting the PCP during informal ICT or formal ICT meeting.

iii. The Molina Dual Options Care Coordinator will be involved during assessments, ICP creation and follow-up, transitions of care between settings, routine case management follow-up, and significant changes in the Member's health status. In addition, the Member may be referred to Molina's ICM program from other Molina Dual Options Staff (i.e. UM staff, Pharmacists, requests for assistance from PCPs, requests for assistance from Members/caregivers, etc.) when Member needs warrant. Transitions in care and significant changes in health status that need follow-up will be identified when services requiring prior authorization are requested by the Member's PCP or other Providers such as inpatient admits (signaling a transition in care or complex medical need). The PCP and ICT will decide when additional ICT meetings are necessary and will schedule them on "as needed" basis.

iv. The ICT will hold regular meetings for Members with complex health care needs and/or complex transition issues. Members will be chosen for case conferences based on need as identified by the Molina Dual Options Care Coordinator, when referred by their Provider or at the request of the Member/representative/caregiver. All participants of the ICT will be invited to the case conference. The Molina Dual Options Care Coordinator will provide a case conference summary for each Member case discussed, when requested by an ICT participant. The summary is then reviewed with the Member to ensure that they are comfortable with the ICP. The ICP is updated with the Member agreement based on the case conference recommendations in alignment with Providers' treatment plans. Case conference summaries will be provided to all applicable ICT participants as determined by the Member or their representative upon request.

v. Communication between ICT participants will be compliant with all applicable HIPAA regulations and will occur in multiple ways including:

- The Molina Dual Options Care Coordinator may facilitate sharing of Member's health and LTSS records from ICT Providers before, during, and after transitions in care settings and during significant changes in the health status of Members, for those health services that require prior authorization, or during the course of regular care management activities.
- Through consultations among those involved in the Member's care, as warranted, county BH Care Coordinators, social workers, psychiatrists, home health workers, PCPs, Molina medical directors, pharmacists, dieticians, medical specialists, LTSS Providers and agencies, family members, authorized representative(s) and other caregivers.
- Case conference summaries available to all Members and active participants of the ICT based on Member preference.
- Updated ICPs are reviewed and shared with participants of the ICT as often as determined by regulatory requirements, with significant changes in health status, or at minimum annually by clinical Molina staff in conjunction with annual Health Risk Assessments.

1. **Provider Network -** Molina Dual Options maintains a network of Providers and facilities that has a special expertise in the care of dual eligible Members. This population has a disproportionate share of physical and mental/behavioral health disabilities. Molina Dual Options' network is designed to provide access to medical care for this population.

   Molina Dual Options' network has facilities with special expertise to care for its Members including:

   - Acute Care Hospitals
   - Long Term Acute Care Facilities
   - Skilled Nursing Facilities
   - Rehabilitation Facilities (Outpatient and Inpatient)
   - Mental/Behavioral Health/Substance Abuse Inpatient Facilities
   - Mental/Behavioral Health/Substance Abuse Outpatient Facilities
   - Outpatient Surgery Centers (Hospital-based and Freestanding)
   - Laboratory Facilities (Hospital-based and Freestanding)
   - Radiology Imaging Centers (Hospital-based and Freestanding)
   - Renal Dialysis Centers
   - Emergency Departments (Hospital-based)
   - Urgent Care Centers (Hospital-based and Freestanding)
   - Diabetes Education Centers (Hospital-based)

   Molina Dual Options has a large community based network of medical and ancillary Providers with many having special expertise including:

- Primary Care Providers – Internal Medicine, Family Medicine, Geriatric
- Medical Specialists (all medical specialties) including specifically Orthopedics, Neurology, Physical Medicine and Rehabilitation, Cardiology, Gastroenterology, Pulmonology, Nephrology, Rheumatology, Radiology and General Surgery.
- Mental/Behavioral Health Providers – Psychiatry, clinical psychology, Masters or above level licensed clinical social work, certified substance abuse specialist.
- Ancillary Providers – Physical therapists, occupational therapists, speech/ language pathology, chiropractic, podiatry.
- Nursing professionals – Registered nurses, nurse Providers, nurse educators.

Molina Dual Options has a credentialing program to ensure all network Providers meet clearly defined criteria and standards. The credentialing program outlines criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners and facilities for participation in the Molina Dual Options network. These criteria have been designed to assess a Provider's ability to deliver care. The credentialing program defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina Dual Options network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation. Providers must be recredentialed every 36-months.

The Member's PCP is primarily responsible for determining what medical services a Member needs. For Members receiving treatment primarily through specialist physician, the specialist may be primarily responsible for determining needed medical services. The PCP is assisted by the Molina Dual Options Care Management Team, medical specialty consultants, ancillary Providers, mental/behavioral health Providers and Members or their caregivers in making these determinations. For Members undergoing transitions in health care settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services.

Molina Dual Options will assure that specialized services are delivered in a timely and quality way by the following:

- Assuring that services requiring prior authorization are processed and that notification is sent as soon as required by the Member's health but no later than timelines outlined in CMS regulations.
- Directing care to credentialed network Providers when appropriate.
- Monitoring access to care reports and grievance reports regarding timely or quality care.

Molina Dual Options will use nationally recognized, evidence based clinical practice guidelines. Molina Medical Directors will select clinical practice guidelines that are relevant to the D-SNP population. These clinical practice guidelines will be communicated to Providers utilizing Provider newsletter and the Molina Dual Options website. Molina Dual Options will annually measure Provider compliance with important aspects of the clinical practice guidelines and report results to Providers.

2. Model of Care Training

All contracted Primary Care and key high-volume Specialty Providers who have been identified as routinely directly or indirectly facilitating and/or providing Medicare Part C or D benefits for Molina Dual Options Members will be required to complete the Model of Care training and provide attestation of training completion. Providers will have access to the Model of Care training via the Molina website. Providers may also participate in web-based or in person training sessions on the Model of Care trainings. Molina will issue a written request to Providers to participate in Model of Care training. The Molina Dual Options Provider Services department will identify key groups and may conduct specific in-person or web-based trainings with those groups. The development of Model of Care training materials will be the responsibility of a designated Molina Services Program Director or Medical Director. Implementation and oversight of completion of training will be the responsibility of a designated Molina Dual Options Compliance staff (employees) and a designated Molina Provider Services staff (Providers). Employees will be required to complete training or undergo disciplinary action in accordance with Molina policies on completion of required training.

3. **Communication -** Molina will monitor and coordinate care for Members using an integrated communication system between Members/representative(s)/ caregiver(s), the Molina Dual Options ICT, other Molina staff, Providers and CMS. Communications structure includes the following elements:

    a. Molina Dual Options utilizes state of the art telephonic communications systems for telephonic interaction between Molina Dual Options staff and all other stakeholders with capabilities for call center queues, call center reporting, computer screen sharing (available only to Molina Dual Options staff) and audio conferencing. Molina Dual Options maintains Member and Provider services call centers during CMS mandated business hours and a Nurse Advice Line (after hours) that Members and Providers may use for communication and inquiries. Interactive voice response systems may be used for Member assessment data gathering as well as general health care reminders. Electronic fax capability and the Provider Portal allow for the electronic transmission of data for authorization purposes and transitions between settings. Faxed and electronic information is maintained in the Member's Molina record.
    b. For communication of a general nature Molina Dual Options uses newsletters (Provider and Member), the Molina Dual Options website and blast fax communications (Providers only). Molina Dual Options may also use secure web-based interfaces for Member assessment, staff training, Provider inquiries and Provider training.
    c. For communication between participants of the ICT, Molina Dual Options has available audio conferencing and audio/video conferencing (Molina staff only). Most regular and ad-hoc ICT meetings will be held on a face-to-face basis with PCPs, other Providers and Member/caregivers joining via audio conferencing as needed.
    d. Written and fax documentation from Members and Providers (clinical records, appeals, grievances) when received will be routed through secure mail room procedures to appropriate parties for tracking and resolution.
    e. Email communication may be exchanged with Providers and CMS.

f. Direct person-to-person communication may also occur between various stakeholders and Molina Dual Options.
g. Molina Quality Improvement Committees and Sub-Committees will meet regularly on a face-to-face basis with Committee members not able to attend in person attending via audio conferencing.

Tracking and documentation of communications occurs utilizing the following:

a. The QNXT call tracking system will be used to document all significant telephonic conversations regarding inquiries from Members/caregivers and Providers. All telephonically received grievances will be documented in the QNXT call tracking system. QNXT call tracking allows storage of a record of inquiries and grievances, status reporting and outcomes reporting.
b. Communication between ICT participants and/or stakeholders will be documented in the Care Management electronic platform. This documentation allows tracking and archiving of discussions. Written meeting summaries may be used when issues discussed are not easily documented using the electronic means documented above.
c. Written and faxed communications when received are stored in an electronic document storage solution and archived to preserve the data. Written documents related to appeals and grievances result in a call tracking entry made in QNXT call tracking when they are received allowing electronic tracking of status and resolution.
d. Email communication with stakeholders is archived in the Molina Dual Options email server.
e. Direct person-to-person communication will result in an electronic care or utilization management platform call tracking entry or a written summary depending on the situation.
f. Molina Dual Options Committee meetings will result in official meeting minutes that will be archived for future reference.

A designated Molina Dual Options Quality Improvement Director will have responsibility to oversee, monitor and evaluate the effectiveness of the Communication Program.

4. **Performance and Health Outcomes Measurement -** Molina Dual Options collects, analyzes reports and acts on data evaluating the Model of Care. To evaluate the Model of Care, Molina Dual Options may collect data from multiple sources including:

a. Administrative (demographics, call center data)
b. Authorizations
c. CAHPS®
d. Call Tracking
e. Claims
f. Clinical Care Advance (Care/Case/Disease Management Program data)
g. Encounters
h. HEDIS®

i. HOS
j. Medical Record Reviews
k. Pharmacy
l. Provider Access Survey
m. Provider Satisfaction Survey
n. Risk Assessments
o. Utilization
p. Chronic Disease Self-Management Plan (CDSMP) Assessment Results
q. Case Management Satisfaction Survey

Molina Dual Options will use internal Quality Improvement Specialists, External Survey Vendors and Healthcare Analysts to collect analyze and report on the above data using manual and electronic analysis. Data analyzed and reported on will demonstrate the following:

a. Improved Member access to services and benefits.
b. Improved health status.
c. Adequate service delivery processes.
d. Use of evidence based clinical practice guidelines for management of chronic conditions.
e. Participation by Members/caregivers and ICT participants in care planning.
f. Utilization of supplementary benefits.
g. Member use of communication mechanisms.
h. Satisfaction with Molina Dual Options' Case Management Program.

Molina Dual Options will submit CMS required public reporting data including:

a. HEDIS® Data
b. SNP Structure and Process Measures
c. Health Outcomes Survey
d. CAHPS® Survey

Molina Dual Options will submit CMS required reporting data including some of the following:

a. Audits of health information for accuracy and appropriateness.
b. Member/caregiver education for frequency and appropriateness.
c. Clinical outcomes.
d. Mental/Behavioral health/psychiatric services utilization rates.
e. Complaints, grievances, services and benefits denials.
f. Disease management indicators.
g. Disease management referrals for timeliness and appropriateness.
h. Emergency room utilization rates.
i. Enrollment/disenrollment rates.
j. Evidence-based clinical guidelines or protocols utilization rates.

k. Fall and injury occurrences.
l. Facilitation of Member developing advance directives/health proxy.
m. Functional/ADLs status/deficits.
n. Home meal delivery service utilization rates.
o. Hospice referral and utilization rates.
p. Hospital admissions/readmissions.
q. Hospital discharge outreach and follow-up rates.
r. Immunization rates.
s. Medication compliance/utilization rates.
t. Medication errors/adverse drug events.
u. Medication therapy management effectiveness.
v. Mortality reviews.
w. Pain and symptoms management effectiveness.
x. Policies and procedures for effectiveness and staff compliance.
y. Preventive programs utilization rates (e.g., smoking cessation).
z. Preventive screening rates.
aa. Primary care visit utilization rates.
bb. Satisfaction surveys for Members/caregivers.
cc. Satisfaction surveys for Provider network.
dd. Screening for depression and drug/alcohol abuse.
ee. Screening for elder/physical/sexual abuse.
ff. Skilled nursing facility placement/readmission rates.
gg. Skilled nursing facility level of care Members living in the community having admissions/readmissions to skilled nursing facilities.
hh. Urinary incontinence rates.
ii. Wellness program utilization rates.

Molina Dual Options will use the above data collection, analysis and reporting to develop a comprehensive evaluation of the effectiveness of the Molina Dual Options Model of Care. The evaluation will include identifying and acting on opportunities to improve the program. A designated Molina Dual Options Quality Improvement Director and/or Medical Director will have responsibility for monitoring and evaluating the Model of Care. Molina Dual Options will notify stakeholders of improvements to the Model of Care by posting the HEDIS® and CAHPS® Model of Care evaluation results on its website.

5. **Care Management for the Most Vulnerable Subpopulations –** Molina Dual Options identifies the most vulnerable Members as those who may have experienced a change in health status, transition of care setting, a diagnosis that requires extensive use of resources or those who need help navigating the health care system due to inadequate social determinants of health. Molina Dual Options' most vulnerable population includes Members who may be at imminent risk of:

- An emergency department visit.
- An inpatient admission.
- Institutionalization related to environmental and/or social issues.
- Transferring to a home or community setting but are currently institutionalized.
- Facing an imminent loss of current living arrangement.

Molina Dual Options identifies the following vulnerable sub-populations through:

- Historical data.
- The assessment process.
- Monitoring of utilization activity.
- Member or family report.
- Provider referral.

The needs of the most vulnerable population are met within the Model of Care by early identification and higher stratification/priority in the Molina Dual Options ICM Program. These Members are managed more closely and frequently by Molina Dual Options' Care Coordinator and the ICT, as warranted, based on Member's needs and preferences. Close monitoring ensures that Members receive all necessary services and care plans are updated timely and adequately before, during and after transitions in health care settings or changes in health care status.

VIII. Long-Term Care and Services

Home and Community-Based Programs

The Home and Community-Based Services (HCBS) Long Term Services and Support (LTSS) waiver program offers service packages to individuals whose care needs would otherwise qualify them for Medicaid-funded institutional care in nursing homes, hospitals or intermediate care facilities for those with Intellectually Disabled and Related Disabilities (ID/RD).

LTSS benefits are provided over an extended period, mainly in Member homes and communities, but also in facility-based settings such as nursing facilities as specified in his/her Individualized Care Plan. Overall, Molina Dual Options' care team model promotes improved utilization of home and community-based services to avoid hospitalization and nursing facility care. Molina Dual Options care coordinators will work closely with LTSS centers and staff to expedite evaluation and access to services.

Molina Dual Options program available to Members provides seamless coordination between medical care, LTSS, and mental health and substance use benefits covered by Medicare and Medicaid. Much of this coordination requires a partnership between Molina Dual Options and various county agencies that provide certain LTSS benefits and services.

The program offers a broad range of personal, social and medical services that assist people who have functional or cognitive limitations in their ability to perform self-care and other activities necessary to live independently. The program also offers support to family caregivers.

Services that may be available through the HCBS include**:**

- Adult Day Care
- Home Care Attendant
- Chore Services
- Home Delivered Meals
- Independent Living Assistance Services
- Nutritional Consultation Services
- Pest Control Services
- Social Work Counseling Service
- Waiver Transportation Services
- Assisted Living Services
- Enhanced Community Living Service
- Home Medical Equipment and Supplemental Adaptive and Assistive Devices
- Home Modification Maintenance and Repair
- Personal Care Aide Services
- Waiver Nursing Services
- Homemaker Services
- Personal Emergency Response
- Out of Home Respite Care Services
- Community Transition Services
- Alternative Meal Services

IX. Behavioral Health and Alcohol and Other Drug Treatment Services

Behavioral health counseling and therapy services means interaction with a person serviced in which the focus is on treatment of the person's mental illness or emotional disturbance. When the person served is a child or adolescent, the interaction may also be with the family Members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the Individualized Care Plan (ICP).

Managing care for mentally ill beneficiaries has the potential to improve service coordination, provide greater flexibility in types of services that are provided, and help to control costs through reduced reliance on hospitalization and institutionalization.

A. Rendering Service Provider Specialties

Behavioral health counseling and therapy services shall be provided and supervised by appropriately qualified and licensed staff.

B. Behavioral Health Services

Behavioral health counseling and therapy service shall consist of a series of time-limited, structured sessions that work toward the attainment of mutually defined goals as identified in the ICP.

Covered services include:

Community Behavioral Health

- Behavioral Health Counseling – Individual and Group
- Case Management
- Community Psychiatric Support Treatment – Individual and Group
- Crisis Intervention
- Mental Health Assessment – Physician and non-Physician
- Partial Hospitalization
- Pharmacological Management

Alcohol and Other Drug Treatment Services

- Assessment
- Alcohol Drug Screening analysis/Lab urinalysis
- Case Management
- Counseling – Individual
- Counseling – Group
- Ambulatory Detoxification

- Crisis Intervention
- Intensive Outpatient
- Medical/Somatic
- Methadone Administration

C. Member Eligibility Requirements

Any eligible Molina Dual Options Member currently receiving services for alcohol or other drug treatment and/or mental health services from a community provider will have the option to continue to receive care from their existing provider during the transition period.

Member Transition of Care Process

Molina Dual Options will, whenever possible, use data files obtained from CMS and/or SCDHHS to identify current behavioral health services received during the year preceding enrollment. Molina Dual Options will prioritize Members who have received behavioral health services in the past year for comprehensive needs. This will ensure assessments occur for high risk Members within the first 30 to 60 days of Membership, and allow for verification of the both the services received and current provider information.

If a Member is identified as being in the course of behavioral health treatment with a non-contracted provider or agency, Molina Care Coordination staff will make outreach attempts to contact the provider to communicate for the purpose of care coordination. In the event a service needs to be added or increased on the existing plan of care, this outreach communication will include a review of the process for submitting service requests.

Additionally, Molina Dual Options Care Coordination staff will request a copy of the existing plan of care that outlines all active BH services a Member is receiving from the provider. When an existing plan of care is received at the start of the transition of care (ToC), Molina Dual Options Utilization Management (UM) staff will be notified to build authorizations in the Molina Dual Options claims and benefits configuration system. A copy of the existing plan of care plan will be made available to CM staff, as well as in the UM clinical database. UM staff will use this information for claims adjudication purposes as needed. Existing plan of care will be interpreted to mean existing treatment plan. Molina Dual Options Care Coordination staff will be available to consult with UM staff as needed for clinical guidance to determine when BH services need to be authorized if they fall outside of the TOC requirements.

When Members are identified as being in an active course of treatment with a non-contracted provider, Molina Dual Options Care Coordination staff will document the provider and services in the Member's care plan and attempt to have regular communication with the BH provider regarding the Member's care plan. These outreach efforts will include telephonic outreach for input on the health risk assessments and care plan. In addition Molina Dual Options will mail both notices regarding Care Coordination services, and a copy of the current care plan, as well as conduct in-person visits to community behavioral health provider agencies as necessary.

Molina Dual Options Care Coordination staff will use a collaborative approach when scheduling in order to involve behavioral health providers in ICT meetings as much as possible. In many cases, behavioral health providers have the most contact with Members receiving behavioral health services and are therefore important Members of the ICT. Moreover, they may be critical in some cases to keeping Members engaged in the ICT process and may play an important role in encouraging Members to attend ICT meetings.

D. Crisis Intervention

Crisis intervention is the process of responding to emergent situations and may include: assessment, immediate stabilization, and the determination of level of care in the least restrictive environment in a manner that is timely, responsive, and therapeutic.

Crisis intervention mental health services need to be accessible, responsive and timely in order to be able to safely de-escalate an individual or situation, provide hospital pre-screening and mental status evaluation, determine appropriate treatment services, and coordinate the follow through of those services and referral linkages.

Outcomes may include: de-escalating and/or stabilizing the individual and/or environment, linking the individual to the appropriate level of care and services including peer support, assuring safety, developing a crisis plan, providing information as appropriate to family/significant others, and resolving the emergent situation.

Crisis intervention mental health service shall consist of the following required elements:

- Immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention shall be accessible twenty-four hours a day/seven days a week with availability of mobile services and/or a central location site with transportation options. Consultation with a psychiatrist shall also be available twenty-four hours a day/seven days a week;
- Provision for de-escalation, stabilization and/or resolution of the crisis;
- Prior training of personnel providing crisis intervention mental health services that shall include, but not be limited to:
    - Risk assessments;
    - De-escalation techniques/suicide prevention;
    - Mental status evaluation;
    - Available community resources, and procedures for voluntary/involuntary hospitalization;
    - Training and/or certification in first aid and cardio-pulmonary resuscitation (CPR) unless other similarly trained individuals are always present; and
    - Policies and procedures that address coordination with and use of other community and emergency systems.

A crisis plan will be established that includes referral and linkages to appropriate services and coordination with other systems. The crisis plan should also address safety issues, follow-up

instructions, alternative actions/steps to implement should the crisis recur, voluntary/involuntary procedures and the wishes/preferences of the individual and parent/guardian, as appropriate.

Crisis Prevention and Behavioral Health Emergencies

If you are experiencing a behavioral health crisis call 911 or go to your closest emergency room.

E. Partial Hospitalization

Partial hospitalization is an intensive, structured, goal-oriented, distinct and identifiable treatment service that utilizes multiple mental health interventions that address the individualized mental health needs of the client. Partial hospitalization services are clinically indicated by assessment with clear admission and discharge criteria. The purpose and intent of partial hospitalization is to stabilize, increase or sustain the highest level of functioning and promote movement to the least restrictive level of care. The outcome is for the individual to develop the capacity to continue to work towards an improved quality of life with the support of an appropriate level of care.

Partial hospitalization services includes activity therapies, group activities, or other services and programs designed to enhance skills needed for living in the least restrictive environment are allowable.

A partial hospitalization program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities.

Unallowable partial hospitalization activities include, but are not limited to, crafts, general non-therapeutic art projects, recreational outings purely for recreational purposes, exercise groups, etc.

F. Prior Authorization and Referral Guidelines

How to refer Molina Dual Options Members in need of Mental Health/Behavioral Health services:

- Refer to Molina Dual Options Prior Authorization requirements at MolinaHealthcare.com/Duals.
- Behavioral health participating providers should fax the Molina Dual Options Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form to Molina Dual Options as soon as possible to (866) 423-3889.
- For both participating and non-participating providers, if the request is for Inpatient Behavioral Health, Partial Hospitalization, or an Intensive Outpatient Program for psychiatric and substance use disorders, the Molina Dual Options Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form should be faxed as soon as possible to the same number at (866) 423-3889.
- If the admission to Inpatient Behavioral Health is an emergency, Prior Authorization is not needed but the form should be faxed as soon as possible and always within one business day to (866) 423-3889.
- The Molina Dual Options Behavioral Health RN may call the behavioral health provider for additional clinical information, particularly if the Molina Dual Options Inpatient/PHP/IOP/Outpatient Behavioral Health Treatment Request form is not completely filled out.

- Medical necessity will be determined according to the medical necessity criteria outlined in Review Criteria. The Molina Dual Options psychiatrist may also contact the behavioral health provider for a peer-to-peer discussion of the Member behavioral health needs.
- All Requests for Prior Authorization will require the current and existing treatment plan that identifies all medical and behavior health services known.

X. Members' Rights and Responsibilities

Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Dual Options Members as outlined in the Molina Dual Options Member Handbook . The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Handbook can be accessed via the following link: molinahealthcare.com/members/sc/en-us/mem/duals/plan-materials.aspx

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

For additional information, please contact Molina Dual Options at **(855) 237-6178**, seven days a week, 8:00 a.m. to 8:00 p.m., local time. TTY/TDD users, please call 711.

Second Opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request, at no cost, a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

XI. Provider Responsibilities

Nondiscrimination of Healthcare Service Delivery

Molina Dual Options complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act (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 Dual Options website home pages. All Providers who join the Molina Dual Options 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).

For more information about Non-discrimination of Health Care Service Delivery, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Section 1557 Investigations

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

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

Toll-Free: (866) 606-3889
TTY: 711

Online: https://molinahealthcare.AlertLine.com
Email: civil.rights@molinahealthcare.com

Should you or a Molina Dual Options Member need more information, you can refer to the Health and Human Services website: https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina Dual Options in writing (some changes can be made online) at least 30 calendar 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 practice name, 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 on the Provider Portal at https://Provider.MolinaHealthcare.com. You can also notify your Provider Services representative or (855) 237-6178 if your information needs to be updated or corrected.

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

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

National Plan and Provider Enumeration System (NPPES) Data Verification

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

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

Molina Dual Options supports the CMS recommendations around NPPES data verification and encourages our Provider Network to verify Provider data via https://nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQs) document published at the following link: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Dual Options Electronic Solutions Requirements

Molina Dual Options encourages Providers to utilize electronic solutions and tools whenever possible.

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

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

Any Provider entering the network as a contracted Provider will be encouraged to comply with Molina Dual Options' Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Provider Portal within 30 days of entering the Molina Dual Options network.

Molina Dual Options 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 Dual Options. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina Dual Options. Providers may obtain additional information by visiting Molina Dual Options' HIPAA Resource Center located on our website at MolinaHealthcare.com/Duals.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Dual Options Providers include:

- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Provider Portal

Electronic Claims Submission Requirement

Molina Dual Options strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enables Claims to reach Molina Dual Options faster

Molina Dual Options offers the following electronic Claims submission options:

- Submit Claims directly to Molina Dual Options via the Provider Portal. See the Provider Portal Quick Reference Guide at https://Provider.molinahealthcare.com or contact your Provider Services representative for registration and Claim submission guidance.
- Submit Claims to Molina Dual Options through your EDI clearinghouse using Payer ID 46299, refer to our website MolinaHealthcare.com/Duals for additional information.

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

Provider Portal Claims submission includes the ability to:

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

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

Electronic Payment (EFT/ERA) Requirement

Participating Providers are strongly encouraged to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina Dual Options uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina Dual Options' website: MolinaHealthcare.com/Duals.

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 and third-party billers can use the no cost Provider Portal to perform many functions online without the need to call or fax Molina Dual Options. Registration can be performed online and once completed the easy to use tool offers the following features:

- Verify Member eligibility, covered services and view HEDIS needed services (gaps)
- Claims:
    - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
    - Correct/void Claims
    - Add attachments to previously submitted Claims
    - Check Claims status
    - Create and manage Claim templates
    - Create and submit a Claim appeal with attached files
- Prior authorizations/service requests
    - Create and submit prior authorization/service requests
    - Check status of authorization/service requests
- View HEDIS® scores and compare to national benchmarks
- View a roster of assigned Molina Dual Options Members for Primary Care Providers (PCPs)
- Download forms and documents
- Send/receive secure messages to/from Molina Dual Options

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina Dual Options to the Provider. Balance billing a Molina Dual Options Member for covered services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina Dual Options' 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 Dual Options Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Molina Dual Options prior to use. Please contact your Provider Services representative for information and review of proposed materials.

Member Eligibility Verification

Possession of a Molina Dual Options ID card does not guarantee Member eligibility or coverage. Providers should verify eligibility of Molina Dual Options Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina Dual Options places the responsibility for eligibility verification on the Provider of services.

For additional information please refer to the Eligibility and Enrollment in Molina Dual Options section of this Provider Manual.

Member Cost Share

Providers should verify the Molina Dual Options Member's cost share status prior to requiring the 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 Coordination)

Providers are required to participate in and comply with Molina Dual Options Utilization Management and Care Coordination programs, including all policies and procedures regarding Molina Dual Options' facility admission, prior authorization, and Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina Dual Options 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 Dual Options' 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 Dual Options website MolinaHealthcare.com/Duals.

Additional information regarding in-network laboratory Providers and in-network laboratory Provider patient service centers is found on the laboratory Provider's respective websites at https://appointment.questdiagnostics.com/patient/confirmation and https://www.labcorp.com/labs-and-appointments.

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

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

Referrals

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

Providers should direct Molina Dual Options Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from Molina Dual Options except in the case of Emergency Services.

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

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

Providers are required to utilize Molina Dual Options' In-Network Referral Form when referring a Member to an in-network specialist for consultation and treatment.

The In-Network Referral Form is found on the Molina Dual Options website at: MolinaHealthcare.com/Duals

Treatment Alternatives and Communication with Members

Molina Dual Options endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina Dual Options 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 Dual Options' drug formularies and prescription policies. For additional information please refer to the Pharmacy section of this Provider Manual.

Participation in Quality Programs

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

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

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

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

Molina Dual Options requires that Providers respect the privacy of Molina Dual Options Members (including Molina Dual Options Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. For additional information please refer to the Compliance section of this Provider Manual.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina Dual Options' Grievance Program and cooperate with Molina Dual Options in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than ten years and retained further if the records are under review or audit until such time that the review or audit is complete.

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

Participation in Credentialing

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

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

More information about Molina Dual Options' Credentialing program, including Policies and Procedures is available in the Credentialing and Recredentialing section of this Provider Manual.

Delegation

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

XII. Claims and Compensation

Hospital-Acquired Conditions and Present on Admission Program

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

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

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries
    e. Burn
    f. Other Injuries
6. Manifestations of Poor Glycemic Control
    a. Hypoglycemic Coma
    b. Diabetic Ketoacidosis
    c. Non-Ketotic Hyperosmolar Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity

7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a. Laparoscopic Gastric Restrictive Surgery
    b. Laparoscopic Gastric Bypass
    c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

What this means to Providers:

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

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

Claim Submission

Participating Providers are required to submit Claims to Molina Dual Options with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers are encouraged to utilize electronic billing though a clearinghouse or the Provider Portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 46299.

Providers must bill Molina Dual Options 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 Dual Options Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification number (TIN).
- 10-digit National Provider Identifier (NPI).
- Rendering Provider name as applicable.
- Billing/Pay-to Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location information.
- Inpatient facility claims require applicable condition, occurrence and value codes and applicable dates. 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 Dual Options as soon as possible, not to exceed 30 calendar days from the change.

Electronic Claims Submission

Molina Dual Options strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery

- Reduces Claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and Claims reach Molina Dual Options faster

Molina Dual Options offers the following electronic Claims submission options:

- Submit Claims directly to Molina Dual Options via the Provider Portal

Submit Claims to Molina Dual Options via your regular EDI clearinghouse using Payer ID 46299

Provider Portal:

The Provider Portal is a no cost online platform that offers a number of Claims processing features:

- Submit professional (CMS1500) and institutional (UB04) Claims with attached files.
- Correct/void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- Create and manage Claim templates.
- Create and submit a Claim appeal with attached files.

Clearinghouse:

Molina Dual Options 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 Dual Options accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly, your submitter must utilize the latest version of the 837 standard. 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 227CA 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 Dual Options EDI Customer Service line at (866) 409-2935 or email us at EDI.claims@MolinaHealthcare.com for additional support.

Paper Claim Submissions

If it is not possible to send Claims electronically, paper Claims may be submitted to the following address:

Mailing Address:

Molina Healthcare of South Carolina
Molina Dual Options Medicare-Medicaid Plan Claims
PO Box 22664
Long Beach, CA 90801

Physical address for overnight packages:

Molina Healthcare of South Carolina
Molina Dual Options Medicare-Medicaid Plan
PO Box 40309
North Charleston, SC 29423-0309

Please keep the following in mind when submitting paper Claims:

- Paper Claims should be submitted on original red colored CMS 1500 Claims forms.
- Paper Claims must be printed, using black ink.

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

For Members enrolled in a Molina Dual Options plan, Molina Dual Options and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina Dual Options will pay Claims for covered services; however if COB/TPL is determined Molina Dual Options may request recovery post payment, if appropriate. Molina Dual Options will attempt to recover any overpayments paid as the primary payer when another insurance is primary.

Medicaid Coverage for Molina Medicare Members

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

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

Timely Claim Filing

Provider shall promptly submit to Molina Dual Options Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina Dual Options, and shall include all medical records pertaining to the Claim if requested by Molina Dual

Options or otherwise required by Molina Dual Options' policies and procedures. Claims must be submitted by Provider to Molina Dual Options within 365 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina Dual Options is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina Dual Options within 365 calendar 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 Dual Options within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina Dual Options requires coding of both diagnoses and procedures for all Claims. The required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses. For procedures, the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 (HCPCS codes) are required for professional and outpatient Claims. Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System). Furthermore, Molina Dual Options requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

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

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

- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina Dual Options policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina Dual Options.

Telehealth Claims and Billing

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

All telehealth Claims for Molina Dual Options Members must be submitted to Molina Dual Options with correct codes for the plan type. Use the telehealth Place of Service (POS) Code 02, which certifies that the service meets the telehealth requirements. By coding and billing a place of service 02 with a covered telehealth procedure code, the Provider is certifying the Member was present at an eligible originating site when the telehealth services were performed. Modifier GQ is required when applicable. Qualifying telehealth units of service for an originating site must be billed with Q3014 for reimbursement of facility fee.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

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

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a “frequency” code. For a complete list of codes, reference the National Uniform Billing Committee’s (NUBC) Official 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 Dual Options processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The 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.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS – International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Molina Dual Options shall use established industry Claims adjudication and/or clinical practices, State and Federal guidelines, and/or Molina Dual Options policies and data to determine the appropriateness of the billing, coding and payment.

Provider acknowledges Molina Dual Options right to conduct pre and post-payment billing audits. Provider shall cooperate with Molina Dual Options Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Molina Dual Options request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Molina Dual Options may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This sample gives an estimate of the proportion of Claims Molina Dual Options paid in error. The estimated proportion, or error rate, may be projected across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina Dual Options asks that you provide us, or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Molina Dual Options Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina Dual Options reserves the right to recover the full amount paid or due to you.

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. The 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 include the original Claim number.

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 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 segment (Claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

Timely Claim Processing

A complete Claim is a Claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in "Required Elements" above, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

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 Dual Options or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina Dual Options will process the Claim for service as follows:

- 95% of the monthly volume of non-contracted "clean" Claims are to be adjudicated within 30 calendar days of receipt.
- 95% of the monthly volume of contracted Claims are to be adjudicated within 60 calendar days of receipt.
- 95% of the monthly volume of "non-clean" non-contracted Claims shall be paid or denied within 60 calendar days of receipt.

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

Electronic Claim Payment

Participating Providers are encouraged 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 Dual Options uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com/Duals 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 Dual Options 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 Dual Options 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 repayor dispute the overpaid amount within the timeframe allowed Molina Dual Options 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 Dual Options, or the date that the Provider receives a payment from Molina Dual Options that reduces or deducts the Overpayment.

Provider Claim Redeterminations – Contracted Providers

Providers seeking a redetermination of a Claim previously adjudicated must request such action, in writing, utilizing Molina Dual Options' Provider Research and Resolution process within 90 days of Molina Dual Options' original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following:

- Requests must be fully explained as to the reason for redetermination.
- Previous Claim and remittance advice, any other documentation to support the request and a copy of the referral/authorization form (if applicable) must accompany the request.

Note: Corrected Claims are to be directed through the original Claims submission process, clearly identified as a corrected Claim.

All questions pertaining to Claim redetermination requests are to be directed to the Member & Provider Contact Center.

Provider Reconsideration of Delegated Claims – Contracted Providers

Providers requesting a reconsideration, correction or reprocessing of a Claim previously adjudicated by an entity that is delegated for Claims payment must submit their request to the delegated entity responsible for payment of the original Claim.

Provider Claim Reconsideration

Providers seeking a reconsideration of a Claim previously adjudicated must request such action within 90 days of Molina Dual Options' original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a reconsideration and must include the following:

- Requests must be clear and concise and explain the reason for reconsideration.
- Previous Claim and remittance advice, any other documentation to support the request and a copy of the referral/authorization form (if applicable) must accompany the request.
- Requests for Claim reconsideration should be faxed to (877) 901-8182.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina Dual Options to the Provider. Balance billing a Molina Dual Options Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts.

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

Encounter data must be submitted at least once per month, and within 365 calendar days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

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

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

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

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

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

XIII. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina Dual Options 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 Dual Options Provider Services representative.

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

Non-Discriminatory Credentialing and Recredentialing

Molina Dual Options 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 Dual Options from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina Dual Options 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)
- 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 Dual Options fully enrolls/on-boards initial practitioners within 60 calendar days. The 60 calendar days is measured by the number days between the day Molina Dual Options receives a full and complete credentialing application and the day the Agency successfully receives the practitioner on Molina Dual Options' Provider Network Verification (PNV) file. Molina Dual Options will submit the date it receives a full and complete credentialing application to the Agency on the PNV file requested.

Molina Dual Options shall take into account and make allowances for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the practitioner's credentials and shall make allowances for the scheduling of a final decision to meet the 60 day turnaround time.

Criteria for Participation in the Molina Dual Options Network

Molina Dual Options has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina Dual Options 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 Dual Options 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 Dual Options.

Molina Dual Options reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. Molina Dual Options 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 that such waiver is necessary to meet the needs of Molina Dual Options and the community it serves. The refusal of Molina Dual Options 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 Dual Options network. The practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Molina Dual Options network. If the practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina Dual Options 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 Dual Options a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** - 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 Dual Options 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 Dual Options 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 Dual Options 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 Dual Options members.
- **Education** - Practitioner must have graduated from an accredited school with a degree in their designated specialty.
- **Residency Training** - Practitioners must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Molina Dual Options only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.

- **Fellowship Training** - If the practitioner is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.

- **Board Certification** - Board certification in the specialty in which the practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina Dual Options 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 Dual Options network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina Dual Options 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 years of work history as a PCP.

- **Nurse Practitioners & Physician Assistants** - In certain circumstances, Molina Dual Options 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 Dual Options.

- **Work History** - Practitioner must supply most recent five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the practitioner must clarify the gap verbally or in writing. The organization documents a verbal clarification in the practitioner's credentialing file. If the gap in employment exceeds one year, the practitioner must clarify the gap in writing.

- **Malpractice History** - Practitioner 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 Dual Options 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 Dual Options network for any Medicare or Duals (Medicare/Medicaid) lines of business.

[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.

- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina Dual Options 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 Dual Options criteria. This coverage shall extend to Molina Dual Options members and the practitioners activities on Molina Dual Options' 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** – Practitioners must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.
- **Lack of Present Illegal Drug Use** – Practitioner 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 & Medicaid Services (CMS).

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

Molina Dual Options will notify the practitioner immediately in writing in the event that 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 Dual Options 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 files. Practitioner's rights are published on the Molina Dual Options website and are included in this Provider Manual.

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

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina Dual Options.
- 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.
Attn: Credentialing Director
PO Box 2470
Spokane, WA 99210

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

If the practitioner does not respond within 10 calendar days, their application processing will be discontinued, and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina Dual Options 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 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 Dual Options (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 Dual Options website and are included in this Provider Manual. Molina Dual Options will respond to the request within two working days. Molina Dual Options 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 Dual Options Medical Director within two weeks of the decision. Under no circumstance will notifications letters be sent to the practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals are not required.

Recredentialing

Molina Dual Options recredentials every practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager, or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina Dual Options and its subcontractors may not subcontract with an excluded Provider/person. Molina Dual Options and its subcontractors shall terminate subcontracts immediately when Molina Dual Options and its subcontractors become aware of such excluded Provider/person or when Molina Dual Options and its subcontractors receive notice. Molina Dual Options 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 Dual Options and its subcontractors are unable to certify any of the statements in this certification, Molina Dual Options and its subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

Molina Dual Options 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 Dual Options 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 Dual Options monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** - Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** - Molina Dual Options 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 Dual Options 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

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.

XIV. Member Grievances and Appeals

Grievances, Appeals, and State Hearings

Molina Dual Options maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased, and appropriate resolutions. Molina Dual Options Members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

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

This section addresses the identification, review and resolution of member grievances and appeals.

Member Grievances

A grievance is defined as an expression of dissatisfaction with any aspect of Molina Dual Options or participating Provider's operations, provision of health care services, activities, or behaviors.

Members may file a grievance by calling Molina Dual Options' Member Services at (855) 735-5831, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time.

Members may also submit a grievance in writing to:

Molina Healthcare of South Carolina
Attn: Grievance and Appeals Dept.
PO Box 22816
Long Beach, CA 90801-9977
Fax: (562) 499-0610

Members may authorize a designated representative to act on their behalf (hereafter referred to as “representative”). The representative can be a friend, a family member, health care Provider, or an attorney. An authorized Representative Form can be found on Molina Dual Options' Member website.

A Member or an authorized representative may file a grievance at any time with Molina Dual Options or any of its Providers verbally or in writing. If the grievance is filed with the Provider, the Provider must forward the grievance to Molina Dual Options upon receipt.

If the Member or authorized representative has a complaint about disability access or about language assistance, the complaint can be filed with the Office of Civil Rights at the Department of Health and Human Services by calling (800) 368-1019 or writing to:

Timothy Noonan, Regional Manager
Office for Civil Rights

U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street S.W.
Atlanta, GA 30303-8909

The Member may also have rights under the Americans with Disability Act and under State Law. The Member can contact the Healthy Connections Prime Advocate for assistance at (844) 477-4632. TTY users call 711.

If the Member's or authorized representative's complaint is about quality of care, there are two choices for filing a grievance:

- File the grievance about the quality of care directly with the Quality Improvement Organization (QIO) without making a complaint to Molina Dual Options; or
- File the grievance to Molina Dual Options and also to the QIO. If the complaint is made to the QIO, we will work with them to resolve the complaint.

The QIO is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

The phone number for the QIO is (844) 455-8708 (TTY: (855) 843-4776).

A Member or an authorized representative can also file a complaint with Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes complaints seriously and will use this information to help improve the quality of the Medicare program.

If the Member or authorized representative has any other feedback or concerns, or if they feel the plan is not addressing the problem, they can call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call (877) 486-2048. The call is free.

Molina Dual Options will acknowledge a grievance upon receipt. Molina Dual Options will investigate, resolve and notify the Member or representative of the findings verbally and/or in writing. If the grievance is filed in writing, Molina Dual Options will also respond to the grievance in writing. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following time frames:

- Within 24 hours for an expedited grievance. A grievance must be expedited when:
    - The complaint involves Molina Dual Options' decision to invoke an extension relating to an organizational determination or reconsideration.
    - The complaint involves Molina Dual Options' refusal to grant and a Member's request for an expedited organization determination or reconsideration.
- 30 calendar days after the receipt of a formal grievance.

If Molina Dual Options needs more information and the delay is in the Member's best interest, or if the Member or authorized representative asks for more time, Molina Dual Options can take up to 14 more calendar days to resolve a grievance. Molina Dual Options will notify the Member or representative in writing why a 14 calendar day extension is necessary.

All grievances received will be kept confidential except as needed to resolve the issue and respond to the Member or representative.

Member Appeals

Appeals are the request for a review of an action. The Member or their representative acting on their behalf has the right to appeal Molina Dual Options' decision to deny a service.

For Member appeals filed by a representative, Molina Dual Options must have written consent from the Member authorizing someone else to represent them. A determination will not be made if written consent is not received within 15 calendar days from the date the appeal was received.

To get an Appointment of Representative (AOR) form, the Member or representative can:

- Call Member Services at (855) 735-5831, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time and ask for one;
- Visit the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf; or
- Visit Molina Dual Options' website at MolinaHealthcare.com/Duals.

While lack of written consent from the Member does not pose any barrier to the commencement of the appeal process; if it is not received within the time frame, the appeal request will be closed and no determination will be made.

An appeal can be filed verbally or in writing within 60 days from the date of the Notice of Action. The Member, the Member's doctor, another Provider, or the Member's representative can call Molina Dual Options at (855) 735-5831, TTY: 711, 7 days a week, 8 a.m. to 8 p.m., local time to file a standard or expedited appeal. Unless the Member or Provider appealing on behalf of the Member requests an expedited appeal resolution, appeals filed verbally must be confirmed in writing. Appeals can be submitted in writing to:

Molina Dual Options Medicare-Medicaid Plan
Attn: Grievance and Appeals Dept.
PO Box 22816
Long Beach, CA 90801-9977
Fax: (562) 499-0610

Molina Dual Options will send a written acknowledgement in response to written appeal requests received. Molina Dual Options will respond to the Member or representative in writing with a decision as expeditiously as the Member's health condition requires, but no later than 15 calendar days from receipt of appeal. However, if the Member asks for more time or if Molina Dual Options needs to gather more information, Molina Dual Options can take up to 14 more calendar days. If

Molina Dual Options decides to take extra days to make the decision, Molina Dual Options will send a letter that explains why we need more time and how an extension is in the best interest of the Member.

The Member or their representative should state the reason they feel the service should be approved and be prepared to provide any additional information for review. For a copy of the Grievance and Appeal Form, please visit https://www.molinahealthcare.com/members/sc/en-US/mem/medicaid/overvw/quality/grievances.aspx.
https://www.molinahealthcare.com/members/sc/en-US/mem/medicaid/overvw/quality/~/media/Molina/PublicWebsite/PDF/members/sc/en-US/Medicaid/Member-Grievance-Request-Form.pdf

Molina Dual Options has an expedited process for reviewing Member appeals when the standard resolution time frame could seriously jeopardize the Member's life, health or ability to attain, maintain or regain maximum function.

Expedited Member appeals may be requested by the Member or representative orally or in writing. Molina Dual Options will promptly inform the Member or representative of the decision whether to expedite the appeal within 24 hours of receipt. With few exceptions, an expedited Member appeal will be resolved as expeditiously as the Member's health condition requires but no later than 72 hours from receipt of the appeal. If Molina Dual Options denies the request for an expedited resolution of an appeal, the appeal will be transferred to the standard resolution time frame of 15 calendar days from the date the appeal was received, and the Member will be contacted via telephone and a written notification explaining the denial of an expedited appeal resolution within two calendar days.

For expedited appeals, the Member or representative will be notified of an expedited resolution in writing within 72 hours of receipt of the appeal. However, if the Member asks for more time or if Molina Dual Options needs to gather more information, Molina Dual Options can take up to 14 more calendar days. If Molina Dual Options decides to take extra days to make the decision, Molina Dual Options will send a letter that explains why we need more time and how an extension is in the best interest of the Member.

No punitive action will be taken against a Member or representative for filing an expedited Member appeal.

If Molina Dual Options previously approved coverage for a service but then decided to change or stop the service before the approval expired, we will send the Member a notice at least ten days before taking the action. If the Member or representative acting on behalf of the Member disagrees with the action, the Member or representative can file an appeal with Molina Dual Options and ask that the Member's benefits continue while the appeal is pending. The Member or representative must make the request on or before the later of the following in order to continue benefits:

- Within ten days of the mailing date of the Notice of Action; or
- The intended effective date of the action.

State Fair Hearings

A Member has the right to request a State Fair Hearing from the South Carolina Department of Health and Human Services (SCDHHS) anytime there is dissatisfaction with Molina Dual Options' decision related to Medicaid services. The filing of an internal appeal and exhaustion of Molina Dual Options' internal appeal process is a prerequisite to requesting a State Fair Hearing.

Members are notified of their right to a State Fair Hearing in all of the following situations:

- A service denial (in whole or in part).
- Reduction, suspension or termination of a previously authorized service.
- A Member is being billed by a Provider due to a denial of payment and Molina Dual Options upholds the decision to deny payment to the Provider.

A health care Provider may act as the Member's authorized representative or as a witness for the Member at the hearing with the Member's written consent.

Appeal decisions not wholly resolved in the Member's favor will include information on how to request a State Fair Hearing and instructions on how to continue receiving benefits if benefits were denied until the time the State hearing is scheduled. If the State hearing upholds Molina Dual Options' decision and continued benefits were requested in the interim, the Member may be responsible for payment.

XV. Medicare Part D

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug. A decision concerning a tiering exception request, a formulary exception request a decision on the amount of cost sharing for a drug or whether a Member has or has not satisfied a Prior Authorization or other UM requirement.

Any party to a coverage determination, (e.g., a Member, a Member's representative) may request that the determination be appealed. A Member, a Member's representative, or Provider, are the only parties who may request that Molina Dual Options expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited depending on the urgency of the Member's request.

A. Appeals/Redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney, Provider, or authorized representative) to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to 60 days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven days. If an expedited appeal is required for and emergent situation, then the decision will be made within 72 hours of the request.

At any time during the appeal process, the Member or personal representative may submit written comments, papers or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the Member has the right to send an appeal in writing to the Independent Review Entity (IRE) within 60 days of receipt of the appeal decision. The IRE has seven days to make a decision for a standard appeal/reconsideration and 72 hours for an expedited request. The IRE will notify Molina Dual Options and the Member of the decision. When an expedited review is requested, the IRE will make a decision within 72 hours. If the IRE changes the Molina Dual Options decision, authorization for service must be made within 72 hours for standard appeals and within 24 hours for expedited appeals.

Payment appeals must be paid within 30 days from the date the plan receives notice of the reversal.

If the IRE upholds Molina Dual Options' denial, they will inform the Member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors Molina Dual Options' compliance with determinations to decisions that fully or partially reverse an original Molina Dual Options denial. The IRE is currently MAXIMUS Federal Services, Inc.

B. Part D Prescription Drug Exception Policy

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits a Member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a Member can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction, or Prior Authorization requirement).

Molina Dual Options is committed to providing access to medically necessary prescription drugs to Members of Molina Dual Options. If a drug is prescribed that is not on Molina Dual Options' formulary, the Member or Member's representative may file for an exception. All exceptions and appeals are handled at the plan level (on-site) and are not delegated to another entity. Please see below for contact information by plan for personnel who handle the exceptions. Members or the Member's representatives (who can include Providers and pharmacists) may call, write, fax, or e-mail Molina Dual Options' exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D Exceptions and Appeals Contact Information: call **Molina Dual Options at (866) 472-4584 or fax (866) 450-3914.**

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) Committee on an annual basis at minimum. Exception/Prior Authorization criteria are also reviewed and approved by a P&T Committee.

1. **Formulary –** A formulary is a list of medications selected by Molina Dual Options in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Molina Dual Options will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Molina Dual Options network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA approved or compendia supported for the diagnosis for which it is being used), and other plan rules are followed.

   Formularies may be different depending on the Molina Dual Options and will change over time. Current formularies for all products may be downloaded from our Website at MolinaHealthcare.com/Duals.

2. **Co-payments for Part D –** Under the Molina Dual Options Program, the Member does not have an out-of-pocket responsibility.

3. **Restrictions on Molina Dual Options Drug Coverage**
   Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Molina Dual Options requires Prior Authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, Molina Dual Options may not cover the drug.
- **Quantity Limits:** For certain drugs, Molina Dual Options limits the amount of the drug that it will cover.
- **Step Therapy:** In some cases, Molina Dual Options requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if drug A and drug B both treat a medical condition, Molina Dual Options may not cover drug B unless drug A is tried first.
- **Part B Medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. 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 Dual Options Pharmacy and Therapeutics Committee.

4. Non-Covered Molina Dual Options Part D Drugs:

- Agents when used for anorexia, weight loss, or weight gain (no mention of medically necessary).
- Agents when used to promote fertility.
- Agents used for cosmetic purposes or hair growth.
- Agents used for symptomatic relief of cough or colds.
- Prescription vitamins and minerals, except those used for fluoride preparations.
- Non-prescription drugs, except those medications listed as part of Molina Dual Options' over-the-counter (OTC) monthly benefit as applicable and depending on the plan.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
- Molina Dual Options Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to Molina Dual Options Medicaid.
- Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or compendia supported for the diagnosis for which they are being used; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System).

5. There may be differences between the Medicare and Medicaid Formularies – The Molina Dual Options Formulary includes many injectable drugs not typically found in its Medicaid Formularies such as those for the aged, blind and disabled.

6. **Requesting a Molina Dual Options Formulary Exception –** Molina Dual Options product drug Prior Authorizations are called exceptions, which are required when your patient needs a drug that is not on the Formulary. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an exception. (The process for filing an exception is predominantly a fax based system.) The form for exception requests is available on the Molina Dual Options website MolinaHealthcare.com/Duals.

7. **Requesting a Molina Dual Options Formulary Redetermination (Appeal) –** The appeal process involves an adverse determination regarding Molina Dual Options issuing a denial for a requested drug or Claim payment. If the Member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, he/she may request a redetermination (appeal) from Molina Dual Options by completing the appeal form sent with the Notice of Denial.

   A Member, a Member's appointed representative or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information which may help Molina Dual Options with the processing of the appeal. An appeal must be submitted in writing and filed within 60 calendar days from the date that the determination was rendered.

   - A standard appeal may be submitted to Molina Dual Options in writing or can be taken over the telephone. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven calendar days from the date the request for re-determination is received.
   - An expedited appeal can be requested by the Member or by the Provider acting on behalf of the Member in writing or can be taken over the phone. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the request for an expedited appeal, Molina Dual Options will honor this request.
   - If a Member submits an appeal without Provider support, Molina Dual Options will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina Dual Options will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the expedited criteria, Molina Dual Options will render a coverage decision within the standard redetermination time frame of seven calendar days.
   - To submit a verbal request, please call (866) 472-4584. Written appeals must be mailed or faxed (866) 450-3914.

8. **Initiating a Part D Exception (Prior Authorization) Request –** Molina Dual Options will accept requests from Providers or a Member's appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized Molina Dual Options Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within 72 hours/three calendar days after Molina Dual Options receives the completed request.

Molina Dual Options will request submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) Molina Dual Options Pharmacy Technician under the supervision of a pharmacist; 2) Molina Dual Options Pharmacist; or, 3) Chief Medical Officer (CMO) of Molina Dual Options. Review criteria will be made available at the request of the Member or his/her prescribing Provider. Molina Dual Options will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
   - American Hospital Formulary Service Drug Information.
   - DRUGDEX Information System.

b. Requests for off-label use of medications will need to be accompanied with excerpts from one of the two CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.

c. Depending upon the prescribed medication, Molina Dual Options may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes, and medical summaries.

   Denial decisions are only given to the Member or Member's representative by a Pharmacist or CMO of Molina Dual Options. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a Member's right to, and conditions for, obtaining an expedited appeals process.

   If Molina Dual Options denies coverage of the prescribed medication, Molina Dual Options will give the Member a written notice within 72 hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified time frame, Molina Dual Options will start the next level of appeal by sending the Coverage Determination request to the Independent Review Entity (IRE) within 24 hours.

   If a coverage determination is expedited, Molina Dual Options will notify the Member of the coverage determination decision within the 24 hour time frame by telephone and mail the Member a written Expedited Coverage Determination within three calendar days of the oral notification. If Molina Dual Options does not give the Member a written notification within the specified time frame, Molina Dual Options will start the next level of appeal by sending the Coverage Determination request to the IRE within 24 hours.

9. **Initiating a Part D Appeal –** If Molina Dual Options' initial coverage determination is unfavorable, a Member may request a first level of appeal, or redetermination within 60 calendar days from the date of the notice of the coverage determination. In a Standard Appeal Molina Dual Options has up to seven days to make the redetermination, whether favorable or adverse, and notify the Member in writing within seven calendar days from the

date the request for redetermination is received. Members or a Member's prescribing Provider may request Molina Dual Options to expedite a redetermination if the standard appeal time frame of seven days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina Dual Options has up to 72 hours to make the redetermination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for redetermination. If additional information is needed for Molina Dual Options to make a redetermination, Molina Dual Options will request the necessary information within 24 hours of the initial request for an expedited redetermination. Molina Dual Options will inform the Member and prescribing Provider of the conditions for submitting the evidence since the time frame is limited on expedited cases.

10. **The Part D Independent Review Entity (IRE) –** If the redetermination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor is currently MAXIMUS Federal Services, Inc., a CMS contractor that provides second level appeals.

    - **Standard Appeal:** The IRE has up to seven days to make the decision.
    - **Expedited Appeal:** The IRE has up to 72 hours to make the decision.
    - **Administrative Law Judge (ALJ):** If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied.

      Note: Regulatory time frame is not applicable on this level of appeal.
    - **Medicare Appeals Council (MAC):** If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory time frame is not applicable on this level of appeal.

11. **Federal District Court (FDC) –** If the MAC's decision is unfavorable, the Member may appeal to a Federal District Court, if the amount in controversy requirement is satisfied. Note: Regulatory time frame is not applicable on this level of appeal.

12. **Pain Safety Initiative (PSI) Resources**

    Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina Dual Options requires Providers to adhere to Molina Dual Options' 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 Dual Options is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Dual Options Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com/Duals under the Health Resource tab. Please consult with your Provider Services Representative or reference the medication formulary for more information on Molina Dual Options' Pain Safety Initiatives.

XVI. Risk Adjustment Management Program

What is Risk Adjustment?

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

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

Why is Risk Adjustment Important?

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

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for Care Management referral.
- Ensure adequate resources for the acuity levels of Molina Dual Options Members.
- Have the resources to deliver the highest quality of care to Molina Dual Options Members.

Your Role as a Provider

As a Provider, your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as this will ensure Molina Dual Options receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g. diabetic patient needs an eye exam or multiple comorbid conditions) provided by Molina Dual Options and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a face-to-face or telehealth visit with the Member.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina Dual Options is appropriate and accurate. All Claims/encounters submitted to Molina Dual Options are subject to State and/or Federal and internal health plan auditing. If Molina Dual Options is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

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

XVII. Cultural Competency and Linguistic Services

Background

Molina Dual Options works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina Dual Options complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com/Duals, from your local Provider Services representative and by calling Molina Dual Options Provider Services at (855) 237-6178.

Nondiscrimination of Health Care Service Delivery

Molina Dual Options 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 Dual Options website homepages. All Providers who join the Molina Dual Options 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 Dual Options requires Providers to deliver services to Molina Dual Options members without regard to race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Providers must post a non-discrimination notification in a conspicuous location in their office along with translated non-English taglines in the top 15 languages spoken in the State to ensure Molina Dual Options 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/Independent Practice Associations (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 Dual Options Members who are complaining of discrimination to the Molina Dual Options Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

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

Members can mail their complaint to Molina at:

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

Members can also file a civil rights complaint with the U.S. Department of Health and Human Services, OCR. Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html. The form can be mailed to:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Members can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you or a Molina Dual Options Member needs help, call (800) 368-1019 or TTY (800) 537-7697.

Should you or a Molina Dual Options Member need more information, refer to the Health and Human Services website for: https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Cultural Competency

Molina Dual Options is committed to reducing healthcare disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful, culturally competent service delivery. Molina Dual Options integrates Cultural Competency training into

the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

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

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

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

Integrated Quality Improvement – Ensuring Access

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

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

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's Membership
    - Contracted Providers to assess gaps in network demographics

- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina Dual Options' Contact Center toll free at (855) 237-6178. 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 Dual Options 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 Dual Options 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 Dual Options 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 Dual Options.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Molina Dual Options 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 being notified of his or her right to have a qualified interpreter at no cost.

Members with Hearing Impairment

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

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

Nurse Advice Line

Molina Dual Options provides nurse advice services for Members 24 hours per day, seven days per week. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call Molina Dual Options Nurse Advice Line directly: English line (888) 275-8750 or Spanish line at (866) 648-3537, or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on Membership cards.

XVIII. Delegation

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

1. Medical Management
2. Credentialing and Recredentialing
3. Sanction Monitoring for employees and contracted staff at all levels
4. Claims
5. Complex Care Management
6. CMS Preclusion List Monitoring
7. Other Clinical and Administrative Functions

When Molina Dual Options delegates any clinical or administrative functions, Molina Dual Options remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina Dual Options' established delegation criteria and standards. Molina Dual Options' Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina Dual Options' standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina Dual Options must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Dual Options Delegation Oversight staff within the timeline indicated by Molina Dual Options.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina Dual Options' guidelines or regulatory requirements, Molina Dual Options may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina Dual Options may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina Dual Options determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Molina Dual Options Contract Manager.

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