MOLINA HEALTHCARE

Your Extended Family.

Molina Healthcare of South Carolina
4105 Faber Place Dr. Suite 120
Charleston, SC 29405
Phone: (855) 237-6178
Fax: (877) 901-8182

Dear Healthcare Professional:

I would like to extend a personal welcome to Molina Healthcare of South Carolina's participating providers. Enclosed is your Molina Healthcare of South Carolina (MHSC) Provider Manual, written specifically to address the requirements of delivering health care services to MHSC Medicaid members.

This manual is designed to provide you with assistance in all areas of your practice, from making referrals to receiving payment for your services. In some cases, you may have developed internal procedures that meet the standards set out in this manual. In these instances you do not need to change your procedures - as long as they adhere to the standards outlined in this manual.

Also included are samples of the forms needed to fulfill your obligations under your MHSC contract. The sample forms are included to illustrate what is needed for appropriate documentation.

From time to time, this manual will be revised as policies or regulatory requirements change. All changes and updates will be updated and posted to the website as they occur. An updated Provider Manual will be made available annually at www.MolinaHealthcare.com.

Thank you for your active participation in the delivery of quality health care services to our members and we look forward to a long and mutually rewarding experience.

Sincerely,

Thomas Lindquist
President
Molina Healthcare of South Carolina

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to the Molina Healthcare of South Carolina Provider Services Agreement. In the event of any conflicts between this Manual and the Manual distributed with reference to or Molina Medicare or Molina Dual Options (Medicare Medicaid Plan) Members, this Manual shall take precedence over matters concerning the management and care of Molina Healthy Connections Members.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information and policies/procedures for services that the Molina Healthy Connections Plan specifically provides and administers on behalf of Molina Healthcare.

The Provider Manual is reviewed, evaluated and updated as needed and at a minimum annually.

Section 1. Addresses and Phone Numbers

The main address for Molina Healthcare of South Carolina (MHSC) is:

Molina Healthcare of South Carolina
4105 Faber Place Drive, Suite 120
Charleston, SC 29405

The main telephone number that all providers can call for assistance with MHSC is: (855) 237-6178

This number is available on all business days from 8:00am – 5:00pm. Upon calling this number, you will reach prompts to access the following departments:

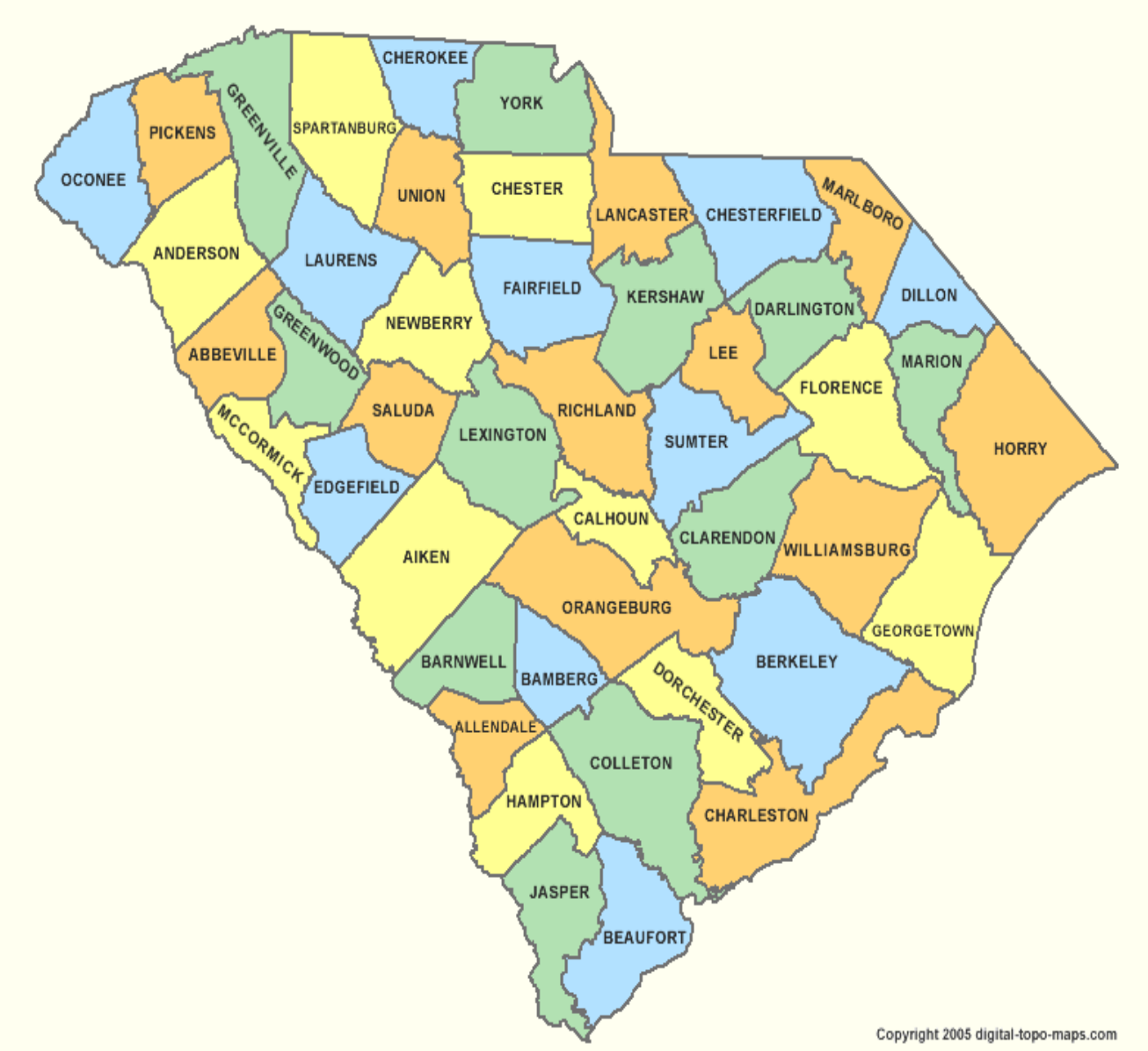
- Provider Services
- Claims
- Claims Recovery
- Healthcare Services
- Health Education & Management
- Behavioral Health
- Pharmacy Services

The Member Services Department is available to MHSC enrolled members from 8:00am – 6:00pm. Providers can refer members to (855) 882-3901; TTY Relay 711 – English & Spanish.

Additionally, the 24-Hour Nurse Advice line is available to all MHSC members. Members can call anytime they need health care information. Registered Nurses are available twenty-four (24) hours a day, seven (7) days a week to assess symptoms and help members with health care decisions.

- English Line (888) 275-8750
- Spanish Line (888) 648-3537
- TTY English (866) 735-2929
- TTY Spanish (866) 833-4703

Molina Healthcare of South Carolina Service Area includes all 46 counties



Section 2. Enrollment, Eligibility and Disenrollment

Enrollment in Medicaid Programs

The Medicaid Program is the program which implements Title XIX of the Social Security Act. It is administered by the South Carolina Department of Health and Human Services (SCDHHS) with a brand name of South Carolina Healthy Connections (SCHC). SCDHHS takes applications and determines eligibility of individuals and families for Medicaid coverage in the state. Further, for the majority of individuals and families who are eligible for Medicaid coverage and are eligible to participate in managed care, SCDHHS contracts with an enrollment brokerage service called South Carolina Healthy Connections Choices (SCHCC) to assist Medicaid-eligible members with enrollment into a South Carolina-based managed care plan.

Only Medicaid recipients who are included in the eligible populations and living in counties with authorized Health Plans are eligible to enroll and receive services from MHSC. Molina Healthcare of South Carolina (MHSC) participates in the SCHC Medicaid Program.

To enroll with MHSC, the member, his/her representative, or his/her responsible parent or guardian must complete and submit an application to SCHCC. More information about SCHCC and the application/enrollment process can be found at www.scchoices.com.

SCHCC will enroll all eligible members with the health plan of their choice. If the member does not choose a plan, SCHCC will assign the member and his/her family to a plan that services the area where the member resides.

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

Effective Date of Enrollment

Coverage shall begin as designated by SCDHHS on the first day of a calendar month. Before being assigned to a plan by SCDHHS, beneficiaries who are eligible for MCO plan assignment are given at least thirty (30) days to choose a plan. Some beneficiaries not eligible for plan assignment may proactively enroll in a Managed Care Plan. Provided continued eligibility is maintained, all members will be enrolled in a Managed Care Organization (MCO) for a period of twelve (12) months. SCDHHS or its Agent will automatically enroll a member into the MCO plan in which he/she was most recently enrolled if the member had a temporary loss of eligibility of less than sixty (60) days. In this circumstance, the consecutive enrollment period will continue as though there has been no break in eligibility, keeping the original twelve (12) month period.

Newborn Enrollment

All newborns of MHSC Members, where the newborn resided in the same household as the mother, are the responsibility of MHSC. To assure continuity of care in the first months of the newborn's life, every effort will be made by SCDHHS to expedite the enrollment of the newborn into MHSC. In cases where the newborn is not living with the mother, the newborn will be covered through fee-for-service Medicaid or be enrolled into a health plan by the person legally responsible for the newborn.

In cases where the mother was enrolled in MHSC in the month of the birth, the newborn will be retroactively assigned to MHSC, and will remain a MHSC member for the remainder of the year unless the mother changes plans during the second or third months of the newborn's life.

All Providers are required to notify MHSC via the Pregnancy Notification Report (included in the Appendix of this manual) immediately after a positive pregnancy test and/or at the first prenatal visit of any member presenting themselves for healthcare services.

Eligibility Verification

Medicaid Programs

The State of South Carolina, through SCDHHS determines eligibility for Medicaid coverage. A person must meet income and resource levels as well as non-income levels, including having U.S citizenship and being a South Carolina resident to be eligible for Medicaid coverage.

Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and MHSC places the responsibility for eligibility verification on the provider of services.

The program is limited to certain Medicaid eligibles who:

- Do not also have Medicare
- Are under 65 years of age
- Are not in a nursing home at the time of enrollment
- Do not have limited benefits such as Healthy Connections Check Up, Specified Low Income Beneficiaries, Emergency Services only, etc.
- Are not participating in a Home or Community Based Waiver program
- Are not participating in Hospice
- Are not participating in the PACE program
- Are not enrolled in a commercial MCO through third party coverage
- Are not enrolled in another Medicaid MCO

Eligibility Listing for Medicaid Programs

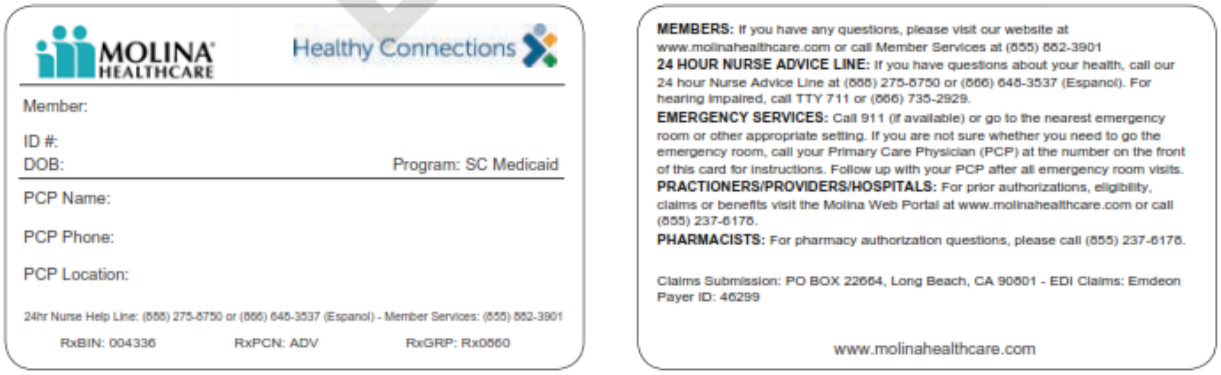
Providers who contract with MHSC may verify a member's eligibility and/or confirm PCP assignment by checking the following:

- MHSC Provider Services at (855) 237-6178
- Molina Healthcare, Inc. Web Portal website, www.MolinaHealthcare.com, Provider Services

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

Identification Cards

Molina Healthcare of South Carolina Sample Member ID card



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

Disenrollment

Voluntary Disenrollment

Members have the right to request to change plans once within the first ninety (90) days of enrollment with a MCO and at the end of each twelve (12) month enrollment period thereafter. Members may request to change plans for cause at any time. Circumstances that constitute cause for disenrollment include: the member moving out of the service srea, MHSC does not provide covered services, member seeks or refuses services based on moral or religious objections, member needs services that are not available within the MHSC network, member's eligibility changes, or other reasons per 42 CFR 438.56(d)(2). Requests for disenrollment must be made to SCHCC. SCDHHS has final determination in all disenrollment requests.

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

Involuntary Disenrollment

Under very limited conditions and in accordance with SCDHHS guidelines, members may be involuntarily disenrolled from a managed care program. With proper written documentation and approval by SCDHHS or its Agent, the following are acceptable reasons for which MHSC may submit Involuntary Disenrollment requests to SCHCC:

- MHSC ceases participation in the Medicaid Program in the member's service area
- Member has moved out of the service area
- Member death
- Member becomes an inmate of a public institution
- Member elects Hospice
- Member's behavior is disruptive, abusive, or uncooperative and continued enrollment impairs the ability to furnish services to this member or other members
- Member's utilization of services is fraudulent or abusive
- Member is placed in a long-term care nursing facility/nursing home for more than ninety (90) continuous days
- Member elects home-and community-based Waiver programs
- Member's Medicaid eligibility category changes, or member otherwise becomes ineligible to participate in Medicaid
- Member becomes age 65 or older

- Member becomes Medicare eligible
- Member enrolls in a commercial MCO
- Member is placed out of home into an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Psychiatric Residential Treatment Facility (PRTF)

PCP Initiated Member Dismissal

A PCP may request the dismissal of a member from his/her practice based on member behavior. Reasons for dismissal must be documented by the PCP and may include:

- A member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least forty-five (45) calendar days prior to the requested effective date.
- A member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her assignment to the provider seriously impairs the provider's ability to furnish services to either the member or other Patients/members within their practice.

This Section does not apply if the member's behavior is attributable to a physical or behavioral condition.

Missed Appointments

The provider will document and follow up on appointments missed and/or canceled by the member. Providers should notify MHSC's Health Education and Health Management Department at (855) 237-6178 when a member misses two consecutive appointments. This will enable MHSC's Care Managers a chance to outreach to members to determine what barriers are preventing them from keeping scheduled appointments. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel. Such a request must be submitted at least forty-five (45) calendar days prior to the requested effective date. The provider agrees not to charge a member for missed appointments.

A member may only be considered for an involuntary disenrollment from a provider's panel after the member has had at least one (1) verbal warning and at least one (1) written warning of the full implications of his or her failure of actions. The member must receive written notification in sixth (6^{th}) grade reading level from the PCP explaining in detail the reasons for dismissal from the practice. Action related to request for involuntary disenrollment conditions must be clearly documented by providers in the member's records and submitted to MHSC. The documentation must include attempts to bring the member into compliance. A member's failure to comply with a written corrective action plan must be documented. For any action to be taken, it is mandatory that copies of all supporting documentation from the member's file are submitted with the request. MHSC will contact the member to educate the member in the consequences of behavior that is disruptive, unruly, abusive or uncooperative and/or assist the member in selecting a new PCP. The current PCP must provide emergency care to the member until the member is transitioned to a new PCP.

PCP Assignment

MHSC will assign a PCP to each member at the time of enrollment. MHSC will take into consideration the member's last PCP (if the PCP is known and available in MHSC's contracted network), closest PCP to the member's home address by ZIP code location, family linkages, age (adults versus children/adolescents) and gender. Members may request a change of PCP's at any time. MHSC will assign all members that are reinstated after a temporary loss of eligibility of one hundred eighty (180) days or less to the PCP who was treating them prior to loss of eligibility unless the member specifically requests another PCP, the PCP no longer participates in MHSC or is at capacity, or the member has changed geographic areas.

MHSC will allow pregnant members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP. MHSC shall make available a pediatrician or other appropriate PCP to all pregnant members for the immediate care of their newborn babies prior to delivery. Once the newborn's enrollment is received by MHSC, if a PCP was not selected by the mother, an appropriate pediatrician will be assigned using the same logic as mentioned above.

PCP Changes

A member may change their PCP at any time. The change will be effective on the date of initial enrollment, if the change is made prior to their effective date. Otherwise, the selected PCP will be effective the first date of the following month of eligibility.

Section 3. Member Rights and Responsibilities (Member Bill of Rights)

This section explains the rights and responsibilities of MHSC members as provided by SCHC and written in the MHSC Member Handbook. South Carolina law requires that health care providers or health care facilities recognize member rights while they are receiving medical care and that members respect the health care provider's or health care facility's right to expect certain behavior on the part of Patients. In South Carolina, these rights are known as the Member Bill of Rights.

Below are the Member Rights and Responsibilities:

MHSC Member Bill of Rights

Members are guaranteed the following rights:

- To receive information about your member rights and responsibilities
- To make recommendations to Molina Healthcare about these member rights and responsibilities
- To be treated with respect and with due consideration for his or her dignity and privacy
- To participate in decisions regarding his or her healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restrains and seclusion
- To be able to request and receive a copy of his or her Medical Records, and request that they be amended or corrected
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished
- To have a candid discussion of appropriate or medically necessary treatment option for your condition regardless of cost or benefit coverage
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition
- To receive all information including but not limited to enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that they may be easily understood
- To receive assistance from both SCDHHS and MHSC in understanding the requirements and benefits of MHSC's plan
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent
- To be notified that oral interpretation is available and how to access those services
- As a potential member, to receive information about the basic features of managed care, which populations may or may not enroll in the program and MHSC's responsibilities for Coordination of Care in a timely manner in order to make an informed choice
- To receive information on MHSC's services, to include, but not limited to:
    - Benefits covered.
    - Procedures for obtaining benefits, including any authorization requirements
    - Any cost sharing requirements
    - Service area
    - Names, locations, telephone numbers of and non-English language spoken by current contracted providers, including at a minimum, primary care physicians, specialists, and hospitals
    - Any restrictions on member's freedom of choice among network providers
    - Providers not accepting new Patients
    - Benefits not offered by MHSC but available to members and how to obtain those benefits, including how transportation is provided

- To receive a complete description of Disenrollment rights at least annually
- To receive notice of any significant changes in the Benefits Package at least thirty (30) days before the intended effective date of the change
- To receive information of the Grievance, Appeal and Fair Hearing procedures, including the right to file
- To be able to file an Appeal, a grievance (complaint) or request a state hearing
- To receive detailed information on emergency and after-hours coverage, to include but not limited to:
    - What constitutes an emergency medical condition, emergency services and Post-Stabilization Services
    - That emergency services do not require Prior Authorization
    - The process and procedures for obtaining Emergency Services
    - The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under plan
    - Member's right to use any hospital or other setting for emergency care
    - Post-Stabilization §422.133(c)
- To receive MHSC's policy on referrals for specialty care and other benefits not provided by the member's PCP
- To have his or her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable
- To exercise these rights without adversely affecting the way MHSC, its Providers or SCDHHS treat the members

Member Responsibilities

- To provide information to their doctor or their health care plan that is needed to provide decisions about their health care
- To be active in decisions about their health care
- To follow the care plans and instructions for care that they have agreed upon with their doctor(s)
- To build and keep a strong Patient-doctor relationship; they have the responsibility to cooperate with their doctor and staff. This includes being on time for their visits or calling the doctor if they need to cancel or reschedule an appointment
- To present their MHSC and SCHC card when receiving medical care and report any fraud or wrongdoing to their health care plan or the proper authorities
- To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- To inform MHSC Member Services of any change of address or any changes to entitlement that could affect continuing eligibility
- To inform MHSC of the loss or theft of member ID card(s)
- To be familiar with MHSC's procedures to the best of their ability
- To call or otherwise contact MHSC to obtain information and have questions clarified
- To access and use preventive care services

Second Opinions

If a member or member's authorized representative does not agree with their provider's plan of care, they have the right to request a second opinion from another provider. Members should call Member Services to find out how to get a second opinion, and under what circumstances a second option can be obtained/approved.

Providers may also request a second opinion for a member if certain clinical requirements are met. Providers should call Provider Services for additional information regarding MHSC's Second Opinion Policy.

Section 4. Benefits and Covered Services

MHSC benefits are comprehensive in nature and include all medically necessary services as included in the general fee-for-service SCHC Medical program as well as some expanded benefits.

There are no co-pays for MHSC members under the age of 19. Additionally, MHSC has eliminated the co-pays for physician visits for members over the age of 19.

This section provides an overview of the medical benefits and covered services for MHSC Members.

SERVICES	COVERAGE	LIMITS & Co-Pays for member over the age of 19
Ambulance Services	Emergency transportation given by: • Ambulance • Air ambulance	
Ambulatory Surgical Center	Covered	Co-pay of $3.40 per date of service
Audiological Some benefits may have limitations. Please call the Provider Services Department for additional information or for a complete list of benefits at (855) 237-6178.	Covered only for children less than 21 years of age. Services include: • Examinations • Fittings and related audiology services • Diagnosis, screening, preventive and corrective services for members with hearing disorder or to determine hearing disorder	Only for children under 21 years of age
Chiropractic Services	Limited to manual manipulation of the spine using the hands to put the bones of the spine back in line Includes certain x-ray procedures	8 per year 2 x-ray procedures per fiscal year
Communicable Disease Services	Exams and reviews including but not limited to: • Contact tracing • Counseling and health education • Certain outreach for directly observed therapy (DOT) for tuberculosis (TB) cases • Help controlling and preventing diseases such as TB, syphilis, and other sexually transmitted diseases (STDs) and HIV/AIDS	
Disease Management	This includes keeping track of any medical conditions/ diseases	

Durable Medical Equipment and Supplies	Covered when medically necessary. Equipment/supplies may require prior approval Medically necessary equipment and supplies, including: • Medical products • Surgical supplies • Wheelchairs • Traction equipment • Walkers • Canes • Crutches • Ventilators • Prosthetic devices • Orthotic devices • Oxygen • Hearing aids and accessories • Diabetes supplies • Any other items when ordered by a doctor as medically necessary	$3.40 per date of service; DME that is rent to purchase payment plan will have the co-pay split evenly among the 10-month rental payment schedule
Emergency Medical Services	Covered	
Family Planning	This includes medical visits for birth control: • Counseling • Birth control drugs and supplies • Pregnancy tests • Lab tests • Tests for sexually transmitted • infections (STIs) • Sterilization • Teen pregnancy prevention program	We do not cover: • Surgery to reverse sterilization • Hysterectomy for sterilization reasons
Hearing Exam, Hearing Aids and Hearing Aid Accessories	Covered for members under age 21. • Hearing exams • Hearing aids and supplies	Only for children under 21 years of age
Newborn Hearing Screening	Covered when rendered to a Newborn in an inPatient hospital setting.	
Home Health Services	Medical visits that take place in the home from time to time which can include: Skilled nursing • Home health aides • Medical supplies and equipment fit for use in the home • Physical, occupational and speech therapy	50 visits are covered annually; additional visits may be allowed with Prior Authorization Co-pay of $3.30 per date of service

InPatient Hospitalization including Services Normally Provided by the Hospital	These hospital services may include: • A semi-private room • Maternity services • Special treatment rooms • Operating rooms • Supplies • Medical tests and X-rays • Drugs the hospital gives you during your stay • Giving you someone else's blood • Radiation therapy • Chemotherapy • Dialysis treatment • Meals and special diets • General nursing services • Anesthesia • Anesthesia for dental procedures when it is an emergency • Rehab in the hospital	Private rooms are not covered unless medically necessary Co-pay $25.00 per admission
Hysterectomies, Sterilizations and Abortions	Covered when they are medically necessary	We do not cover: • Surgery to reverse sterilization • Hysterectomy for sterilization reasons • Abortion services unless they are needed to save a mother's life or to end a pregnancy caused by rape or incest • Signature of consent on the sterilization consent form must not be more than 180 days old at the time of the procedure
Laboratory, X-Rays		
Long Term Care Facilities/Nursing Home Facilities	Covered for first 90 days (or until disenrollment from plan) when approved for and admitted to a long-term care facility	
Maternity Services	This may include the following services: • Doctor visits and all expert care for pregnancy, problems that have to do with pregnancy and after-delivery care when medically necessary • Services from a certified nurse-midwife • Tests such as sonograms • HIV testing, treatment and • counseling (A pregnant member may refuse to take an HIV test) • Birthing center services • Vaginal childbirth and Cesarean section (C-section) • Newborn hearing screenings	
Newborn Circumcision	• Covered for up to 180 days from date of birth without prior authorization • In both in-Patient and out-Patient setting	

OutPatient Pediatric AIDS Clinic Services (OPAC)	Services for HIV-related and exposed children and their families including: • Specialty care • Consults • Counseling • Clinical and lab tests	
OutPatient Hospital Services	Services must be ordered by a doctor and may include: • Care to prevent illness • Rehab • Surgical care • Emergency care • Psychiatric assessment • Substance abuse assessment • Treatment of renal disease • Neurodevelopmental or mental developmental assessment and testing • Family planning • Dialysis • Emergency room use • Drugs ordered by a doctor • Surgery that does not end in a hospital stay • Sterilization	Neurodevelopmental or mental developmental assessments and testing are only for eligible members under 21 years of age Co-pay of $3.40 per claim
Prescription Drugs/Pharmacy		Co-pay of $3.40 per prescription Special Note – no co-pay for children under age of 18 and pregnant women
Preventive and Rehabilitative Services for Primary Care Enhancement (P/RSPCE)	Members who may have medical risk factors get : • Health status assessed • Risk factors identified • Goal-oriented plan of care done or changed	
Physician Services		NO CO-PAYS for MHSC members
Psychiatric Assessment/Treatment Services	Psychiatric assessment services. The following visits may be given by the following types of providers: • Psychiatric interview exam provided by a doctor and private psychiatrist. • Psychiatric interview by a private psychiatrist only • Behavioral health services given in the ER	
Podiatry Services		
Rehabilitation Therapy	Services include: Physical Therapy, Occupational Therapy, Speech Therapy, Audiology and Nursing Services. Children who may have medical risk factors get: • Health status assessed • Risk factors identified • Goal-oriented plan of care done or changed	

Transplant Services	Transplants are covered through Fee for Service. MHSC covers all Pre and Post transplant services for: • Bone Marrow (Autologous InPatient and OutPatient, Allogenic Related and Unrelated, Cord, and Mismatched) • Pancreas • Heart • Liver • Liver with Small Bowel • Liver/Pancreas • Liver/Kidney • Kidney/Pancreas • Lung and Heart/Lung • Multivisceral • Small Bowel MHSC covers pre-transplant, transplant, and post-transplant services for corneal transplants	
Vision Services/Optometrists	Includes exams and hardware for members	Limited to one comprehensive exam every 365 days
Well-Care Visits for adults and children including Early and Periodic Screening, Diagnosis and Treatment/ Well Child Services (EPSDT)	Covered only for children through the month of their 21st birthday. Preventive health care services include: • Health screens • Physical exams • Vaccines • Lab tests, including blood lead level • Teaching you about health topics • Hearing tests • Dental and vision screenings	Well-Care visits end on the month of the child's 21st birthday

Member Co-Pays for Service Covered by Molina Healthcare of South Carolina

MHSC requires a co-payment from its members toward the cost of some of their care. MHSC members may not be denied services if they are unable to pay the co-payment at the time the service is rendered, however, this does not relieve the member of the responsibility for the co-payment. It is the provider's responsibility to collect the co-payment from the member to receive full reimbursement for a service. The amount of the co-payment will be deducted from the MHSC payment for all claims involving co-payments. When a member has Medicare or private insurance, the MHSC co-payment still applies. However, if the sum of the co-payment and the Medicare/third party payment would exceed the MHSC allowed amount, the co-payment should be adjusted or eliminated. In other words, though a provider may receive a primary insurance payment higher than what MHSC would pay, the beneficiary's co-payment should not contribute to the excess revenue.

Co-payment Exclusions

Pursuant to federal regulations, the following members are excluded from co-payment requirements: children under the age of 19, pregnant women, institutionalized individuals (such as persons in a nursing facility or ICF-MR), members of a Federally Recognized Indian Tribe (for services rendered by the Catawbas Service Unit in Rock Hill, SC and when referred to a specialist or other medical provider by the Catawbas Service Unit) and members of the Health Opportunity Account (HOA) program.

Additionally, the following services are not subject to a copayment: Medical equipment and supplies provided by DHEC, Orthodontic services provided by DHEC, Family Planning services, End Stage Renal Disease (ESRD) services, Infusion Center services, Emergency services in the hospital emergency room, Hospice benefits and Waiver services.

Services Covered by SCDHHS through Fee-for-Service Medicaid

- Certain additional Mental Health Services (provided by State Agencies)
- Dental Services (Under age 21)
- Dental Services (Over age 21) SCDHHS offers up to $750 coverage annually for preventative and restorative dental services; Co-payment of $3.40 per date of service is required.
- Other Dental Services (age 21 and over) are covered for the following medical reasons:
    - Organ Transplant
    - Oncology Treatment
    - Total Joint Replacement
    - Heart Valve Replacement
- Non-Emergency Transportation
- Medicaid Adolescent Pregnancy Prevention Services (MAPPS)
- Developmental Evaluation Services (DECs)
- Targeted Case Management (TCM) Services
- Home and Community-Based Waiver Services

Services Not Covered

- Elective Cosmetic Surgery
- Custodial Care Services
- Elective Abortions
- Infertility Services

Prescription Drugs

Prescription drugs are covered through MHSC. There is a member co-pay of $3.40 for prescriptions for members age 19 and older. Pregnant women are exempt from any co-pays. For additional information about the pharmacy benefit and its limitations, please contact the Pharmacy department at (855) 237-6178. A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting MHSC's Provider Service Department at (855) 237-6178.

Injectable Drugs and Infusion Services

Many self-administered and provider-administered injectable products require Prior Authorization (PA). In some cases they will be made available through MHSC's vendor, Caremark Specialty Pharmacy. More information about our Prior Authorization process, including a PA request form, is available in Section 7 of this manual.

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

Access to Behavioral Health Services

Members in need of Behavioral Health Services can be referred by their PCP for services or members can self-refer by calling MHSC at 1-855-882-3901. MHSC is available twenty-four (24) hours a day, seven (7) days a week for behavioral health needs. The services members receive will be confidential. Additionally, members may access certain Behavioral Health Services directly through programs and services offered through the State of South Carolina including the Department of Mental Health (DMH) and the Department of Alcohol and Other Drug Abuse Services (DAODAS). (MHSC is responsible for services provided through DAODAS).

Behavioral health services include:

- InPatient Services (at an acute care hospital)

- OutPatient hospital services
- Psychiatric doctor services

These services may require prior authorization; see Section 7 for additional information.

Emergency Behavioral Health Services

Members are directed to call "911" or go to the nearest emergency room if they need emergency behavioral health services. Examples of emergency behavioral health problems are:

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

Out of Area Emergencies

Members having a behavioral health emergency who cannot get to a MHSC approved providers are directed to do the following:

- Go to the nearest hospital or facility
- Call the number on ID card
- Call member's PCP and follow-up within twenty-four to forty-eight (24 - 48) hours

For out-of-area emergency care, plans will be made to transfer members to an in-network facility when member is stable.

Obtaining Behavioral Health Services

Providers may contact Provider Services at (855) 237-6178 to request assistance in locating a behavioral health provider for a MHSC member. In addition to Behavioral Health services available through MHSC, some services are also available through State Agencies. MHSC is available to assist members in accessing services through these agencies.

Emergency and Ambulance Transportation

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

Examples of conditions considered for emergency transports include, but are not limited to, acute and severe illnesses, untreated fractures, loss of consciousness, semi-consciousness, having a seizure or receiving CPR during transport, acute or severe injuries from auto accidents, and extensive burns.

MHSC covers all transportation services provided via ambulance. These trips may be routine or non-routine, to a Medicaid covered service. MHSC will provide stretcher trips as well as air ambulance or Medivac transportation.

Non-Emergency Medical Transportation

MHSC does not provide non-emergency medical transportation. Non-emergency medical transportation is available to qualified individuals through the SCDHHS transportation broker system.

Medical non-ambulance transportation is defined as transportation of the beneficiary to or from a Medicaid covered service to receive medically necessary care. This transportation is only available to eligible beneficiaries who cannot obtain transportation on their own through other available means, such as family, friends or community resources. MHSC will assist members in obtaining medical transportation services through the SCDHHS transportation broker system as part of its care coordination responsibilities. If one of your members is in need of this service, please have them refer to the DHHS website for a listing of the transportation

broker(s) and phone number(s). A listing is also available in the Appendix of this manual.

If your member needs further assistance, they can also call MHSC Member Services at (855) 882-3901 and one of our representatives will assist them.

Preventive Care

MHSC understands the importance of preventive care and encourages all members to schedule and keep primary care appointments so that overall health can be monitored. MHSC expects providers to deliver preventive care and encourage MHSC members to obtain services in accordance with preventive health guidelines for children, adolescents and adults.

Immunizations

Adult members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the member's PCP. Child members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics and prescribed by the child's PCP.

MHSC covers immunizations not covered through Vaccines for Children (VFC).

The following is a list of immunizations required for children and adolescents.

Immunization	Ages
Hepatitis B (Hep B)	Birth, 1-2 months, and 6-18 months
Rotavirus (RV)	2 months, 4 months and 6 months
Diphtheria, Tetanus, Pertussis (DTaP)	2, 4, 6, 15 – 18 months and one between the ages of 4 and 6 years
Haemophilus influenza type b (HIB)	2, 4, 6 and 12 – 15 months
Pneumococcal (PCV)	2, 4, 6 and 12 – 15 months
Inactivated Poliovirus (IPV)	2, 4, 6 -18 months and one between the ages 4 – 6 years
Influenza	6 months – 18 years, yearly (consult your PCP)
Measles, Mumps, Rubella (MMR)	12 – 15 months and one between the ages of 4 and 6 years
Varicella	12 -15 months and one between the ages of 4 – 6 year
Hepatitis A (Hep A)	Two (2) doses between 12 and 24 months
Tetanus, Diphtheria, Pertussis (Tdap)	11 – 12 years
Human Papilloma Virus (HPV)	Three (3) doses between 11 – 12 years
Meningococcal (MCV)	11 – 12 years

Prenatal Care

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

Well Child Visits

The federal guidelines outlined below specify the minimum requirements included in each Well Child Care (WCC) exam for each of the following age groups; (0-18) months, (2-6) years, and (7-20) years. During Well Child visits, providers are required to deliver the following:

EPDST	Infants (0-18) months	Children (2-6) years	Adolescents (7-20) years
Physical Exam and Health History	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)	• History • Height • Weight • Physical exam (all of these)
Development and Behavior Assessment	• Gross motor • Fine motor • Social/emotional • Nutritional (any one of these)	• Gross motor • Fine motor • Communication • Self-help skills • Cognitive skills • Social/emotional • Regular physical activity • Nutritional (any one of these)	• Social/emotional • Regular physical activity • Nutritional (any one of these)
Mental Health Assessment	Mental health (must be addressed)	Mental health (must be addressed)	• Mental health • Substance abuse (either one of these)
Health Education/ Anticipatory Guidance	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • Passive smoking (either one of these)	• Injury prevention • STD prevention • Smoking/tobacco (any one of these)

We need your help conducting these regular exams in order to meet the SCDHHS targeted state standard. If you have questions or suggestions related to well child care, please call our Health Education line at (855) 237-6178.

Emergency Care Services

Emergency care services are covered by MHSC without an authorization. This also includes non-contracted providers outside of MHSC's service area.

Twenty-four (24) Hour Nurse Advice Line

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

HEALTH LINE (24-Hour Nurse Advice Line)	
English Phone:	(888) 275-8750
Spanish Phone:	(866) 648-3537
TTY:	(866) 735-2929 (English) (866) 833-4703 (Spanish)

MHSC is committed to helping our members:

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

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

Disease Management Programs

MHSC's disease management programs incorporate a collaborative team approach comprised of health education, clinical case management and provider education. The overall goal is to provide better overall quality of life, quality of care and better clinical outcomes for MHSC members. Disease management supports the practitioner-Patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and employs Patient empowerment strategies such as self-management. The programs include proactive member identification and risk stratification, appropriate referral and coordination of care, member education, and provider collaboration. Currently MHSC provides access to two disease management programs, Breathe with Ease Asthma Management Program for children and adults and Building Brighter Days - Adult Depression Management Program.

Program Eligibility Criteria and Referral Source

Members participate in programs for the duration of their eligibility with the plan's coverage or until the member opts out. Each identified member will receive condition specific educational materials and other resources in accordance with their assigned stratification level. Other mailed communications (i.e. newsletters, targeted interventions) also provide information about program services for eligible members. The program model provides an "opt-out" option for members who contact MHSC Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy data
- Encounter data or paid claim with a relevant CMS approved diagnostic and procedural coding
- New member initial health assessment/stratification data
- Practitioner/provider referral
- Nurse Advice referral
- HEDIS data or Quality Improvement programs
- Member self-referral due to general plan promotion of program through member newsletter, the Nurse Advice Line or other member communication

Practitioner/Provider Resources

Contracted practitioner/provider resources and services may include:

- For members actively managed, PCPs are also sent copies of the member completed assessments and care plan for physician consideration in the member's overall treatment plan
- Patient education resources
- Health plan communications such as the Partners in Care physician newsletter promoting the health management programs, including how to enroll Patients and outcomes of the programs
- Clinical Practice Guidelines
- Preventive Health Guidelines

Program Evaluation

To evaluate effectiveness of the programs, the following measures are used:

Asthma Management Program

- Emergency room visit rate for asthma among children and adults (ages 2 and over)
- Hospitalization Rate for asthma among children and adults (ages 2 and over)
- HEDIS asthma medication measures by product line
- Member/family satisfaction with their experience participating in the program
- Analysis of member feedback and complaints with the disease management program
- Active participation based on total eligible members who have had a least one interactive contact

Adult Depression Management Program

- Increase prescription adherence
- Pre-post self-efficacy changes as measured by increased community tenure
- Pre-post behavioral changes in actively enrolled participants
- Analysis of member feedback and complaints with the depression management program
- Active participation based on total eligible members who have had at least one interactive contact
- Reduction in ER visits for any mental health disorder by 10% in the cohort at one year
- Reduction in inPatient stays for any mental health disorder by 10% in the cohort at one year

An annual program evaluation for each program is completed and reviewed by the MHSC Quality Improvement Committee for improvement and/or enhancements.

To find out more about our disease management programs or to refer a Member, please call MHSC Member Services Department at (855) 882-3901.

Health Education and Management

Pregnancy Health Management Program

Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. Our pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. It is the member's choice to be in the program. They can choose to be removed from the program at any time. The program does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to members.

The program activities include early identification of pregnant members, early screening for potential risk factors, provision of telephonic and written trimester appropriate education to all pregnant members and families, referral of high-risk members to prenatal case management, and provision of assessment information to physicians.

MHSC requests that you or someone in your office complete the Pregnancy Notification Report (refer to Appendix for form) and return it to us as soon as pregnancy is confirmed.

Smoking Cessation

Given the diversity of MHSC's membership, a health management program created around smoking cessation should improve the

quality of life among our members and clinical outcomes in the future. Helping our members reduce unhealthy behaviors (i.e., quit tobacco use) will improve their ability to manage pre-existing illnesses or chronic conditions.

MHSC's members who are motivated to quit smoking can access the South Carolina Tobacco Quitline, the only statewide evidence-based telephonic cessation program. The Tobacco Quitline's fax-referral program has ready access and tools that healthcare providers can use to refer MHSC members to the Tobacco Quitline. Participants are eligible for multi-call intervention, support materials and the program covers all 7 FDA-approved medications. Providers can receive feedback from the Tobacco Quitline on the outcome of their referrals once they file HIPAA verification. To refer a member directly to Tobacco Quitline, call 1-800-784-8669 (1-800-QUIT-NOW)

To find out more information about the health management programs, please call MHSC Member Services Department at (855) 882-3901.

Section 5. Provider Rights and Responsibilities

This section describes MHSC's established standards on access to care, newborn notification process, and member marketing information for participating providers. In applying the standards listed below, participating providers have agreed they will not discriminate against any member on the basis of:

- Age
- Race
- Creed
- Color
- Religion
- Sex
- National origin
- Ancestry
- Sexual orientation
- Marital status
- Physical disability
- Mental or sensory handicap
- Place of residence
- Socioeconomic status
- Status as a recipient of Medicaid benefits

Additionally, participating providers or contracted medical groups/IPAs may not limit their practices because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If PCPs choose to close their panel to new members, MHSC must receive thirty (30) days advance notice from the provider, or a timeframe as may be required by applicable State regulations, whichever is greater.

Provider's Bill of Rights

Each healthcare provider who contracts with MHSC to furnish service to MHSC members shall be assured of the following rights:

- A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a MHSC Medicaid member who is his or her other Patient, for the following:
    - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
    - Any information the member needs in order to decide among all relevant treatment options
    - The risks, benefits, and consequences of treatment or non-treatment

- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions

- To receive information on the Grievance, Appeals and Fair Hearing procedures
- To have access to the MCO's Policies and Procedures covering the authorization of services
- To be notified of any decision by MHSC to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested
- To challenge, on behalf of MHSC members, the denial of coverage of, or payment for, medical assistance
- MHSC's provider selection Policies and Procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification

Access to Care Standards

MHSC is committed to providing timely access to care for all members in a safe and healthy environment. MHSC will ensure providers offer hours of operation no less than offered to commercial members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available twenty-four (24) hours a day, seven (7) days a week to members for emergency services. This access may be by telephone. Appointment and waiting time standards are shown below. Any member assigned to a PCP is considered his or her Patient.

For additional information about how MHSC audits access to care, please refer to Section 8 (Quality Improvement) of this manual.

Primary Care Practitioner (PCP)	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Routine Primary Care	Within 4 weeks
Urgent Care	Within forty-eight (48) hours
Emergency Care	Immediately upon presentation at treatment site. Access by telephone for emergent medical conditions.
Walk-in Patients	Should be seen if possible. Urgent needs must be seen within forty-eight hours of walk-in. Non-urgent needs must be seen within routine care guidelines above.
Office Wait Times	Within forty-five (45) minutes for a scheduled appointment of a routine nature
After Hours Care	After-Hours Instruction/Standards
After hours emergency instruction	"If this is an emergency, please hang up and dial 911"
After-Hours Care	Available by phone twenty-four (24) hours/seven (7) days
Behavioral Health	
Types of Care for Appointment	Appointment Wait Time (Appointment Standards)
Non-life Threatening Emergency Care	Within six (6) hours of request
Urgent Care	Within forty-eight (48) hours

Routine Care	Within ten (10) calendar days

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed forty-five (45) minutes. All PCPs are required to monitor waiting times and to adhere to this standard.

After Hours

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. MHSC requires practitioners to maintain a twenty-four (24) hour phone service, seven (7) 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.

Appointment Scheduling

Each practitioner must implement an appointment scheduling system. The following are the minimum standards:

a. The practitioner must have an adequate telephone system to handle Patient volume. Appointment intervals between Patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments

b. A process for documenting missed appointments must be established. When a member does not keep a scheduled appointment, it is to be noted in the member's record and the practitioner is to assess if a visit is still medically indicated. All efforts to notify the member must be documented in the medical record. If a second appointment is missed, the practitioner is to notify the MHSC Member Services Department toll free at (855) 882-3901 or TTY/TDD Relay (711)

c. When the practitioner must cancel a scheduled appointment, the member is given the option of seeing an associate or having the next available appointment time;

d. Special needs of members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using members and members requiring language translation

e. A process for member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms

f. A process must be established for member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit

In applying the standards listed above, participating practitioners/providers have agreed that they will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating practitioner/provider or contracted medical group/IPA may not limit his/her practice because of a member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care.

Women's Open Access

MHSC allows members the option to seek obstetrical and gynecological care from an obstetrician or gynecologist or directly from a participating PCP designated by MHSC as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure members have direct access to participating providers for obstetrical and gynecological services.

Additional information on access to care is available under the Resources tab on the MolinaHealthcare.com website or from the MHSC QI Department toll free at (855) 237-6178.

Pregnancy Notification Process

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

The PCP shall submit to MHSC the Pregnancy Notification Report form (included in the Appendix) within one (1) working day of the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services. Providers shall enter all applicable information in sections (3) and (2) of the form. The form should be faxed to the MHSC Prior Authorization Department at (866) 423-3889.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

MHSC has partnered with SCDHHS, DAODAS, DHEC and DMH to expand and enhance state substance use identification and treatment for pregnant members. Providers are encouraged to screen ALL pregnant women, to include up to twelve (12) months postpartum, utilizing the SBIRT Integrated Screening Tool (form located in Appendix). Keep all completed screening tools in the Patient's record and send copies to the referral resource and to MHSC. Completed tools for MHSC members can be faxed to (866) 423-3889. Two codes can be billed in support of SBIRT services: H0002 (SBIRT behavioral health screening) and H0004 (SBIRT behavioral health brief intervention).

Relocations and Additional Sites

Providers should notify MHSC thirty (30) days in advance when they relocate or open an additional office, or a timeframe as may be required by applicable State regulations, whichever is greater. When this notification is received, a site review of the new office may be conducted before the provider's recredentialing date.

Site and Medical Record-Keeping Practice Reviews

As a part of MHSC's QI Program, providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices. For details regarding these requirements and other QI program expectations, please refer to Section 12 of this manual.

Member Information and Marketing

Any written informational and marketing materials directed toward MHSC members must be developed at the sixth (6^{th}) grade reading level and have prior written consent from MHSC and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials. Neither MHSC nor any contracted providers nor medical groups/IPA may:

- Distribute to its members informational or marketing materials that contain false or misleading information
- Distribute to its members marketing materials selectively within the service area
- Directly or indirectly conduct door-to-door, telephonic, or other cold-call marketing for member enrollment

Section 6. Medical Management

MHSC maintains a medical management program to ensure Patient safety, ensure quality services are being provided as well as detect and prevent fraud, waste and abuse in its programs. The program ensures MHSC only reimburses for services identified as a covered benefit that are medically necessary. Elements of the MHSC medical management program include medical necessity review, prior authorization, inPatient management and review of the use of non-participating providers.

This section on Referrals, Authorizations, and Healthcare Services (Utilization Management) describes procedures that apply to directly contracted MHSC providers. All contracted providers must obtain MHSC's authorization for specific services that require prior approval. MHSC providers must ensure members receive medically necessary health care services in a timely manner without undue interruption. The member's PCP is responsible for:

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

Medical Necessity Standards

Medically necessary means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability (the provision of which may be limited by specific manual provisions, bulletins, and other directives). These services furnished or ordered are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the Patient's needs
- Consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

In conjunction with regulatory guidance from the Centers for Medicare and Medicaid Services (CMS) and industry standards, MHSC only reimburses services provided to its members that are medically necessary. MHSC may conduct a medical necessity review of all requests for authorization and claims, within the specified time frame governed by Federal or State law for all lines of business. This review may take place prospectively, as part of the inPatient admission notification/concurrent review, or occasionally retrospectively, as long as the review complies with Federal or State regulations and the MHSC Healthcare Hospital or Provider Services Agreement.

Healthcare Services (Utilization Management)

Prospective review is a process performed by the Healthcare Services (HCS) staff to evaluate requests for specified services or procedures. Determinations are made by specially trained personnel based on medical necessity and appropriateness, and reflect the application of MHSC's approved review criteria and guidelines. Any denial of services based on medical necessity may only be issued by the Chief Medical Officer (CMO)/Medical Director or his/her designee.

Referral versus Prior Authorization

Referral: An authorization from MHSC is not required to refer a Patient to a participating specialist. In referring a Patient, the PCP should forward pertinent Patient information/findings to the Specialist.

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

Prior Authorization Process

MHSC requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the MHSC Healthcare 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. MHSC prior authorization documents are updated annually and the current documents are posted on the MHSC website.

Providers are encouraged to use the MHSC Prior Authorization Request Form (included in the appendix at the end of this manual). Additionally, MHSC accepts the universal authorization forms located on the SCDHHS website under Reference Tools in the Managed Care section. These forms include: the Universal 17-P Authorization Form, the Universal Medications Prior Authorization Request Form and the Universal Newborn Prior Authorization Form. All of the universal authorization forms are available on the SCDHHS website. If using a different form, the provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, MHSC ID/ State Medicaid number, etc.)
- Provider demographic information (referring provider and referred specialist)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (CMS approved diagnostic and procedural coding)
- Clinical indications necessitating service, pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inPatient requests)

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.

Surgical Procedures

MHSC does not provide additional reimbursement for the use of robotic equipment during surgical procedures.

How to Submit an Authorization Request

Providers should send requests for prior authorizations to the MHSC Healthcare Services Department. Authorization requests may be submitted via MHSC's e-portal atwww.MolinaHealthcare.com twenty-four (24) hours/day, seven (7) days/week. Prior authorizations may also be submitted by fax, mail or in urgent situations by phone. Contact information is listed below.
Phone: (855) 237-6178 FAX: (866) 423-3889

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.
4105 Faber Place Dr. Suite 120
North Charleston, SC 29405

Clinical Information

Pertinent data and information is required by the Healthcare Services (HCS) staff to enable a thorough assessment for medical necessity and to verify that the diagnosis and procedure codes included in the Prior Authorization Request are appropriate and are incorporated into the Authorization. Authorization is based on medical necessity as well as member eligibility and benefit coverage at the time of service.

MHSC 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. MHSC does not accept clinical summaries, telephone summaries or case manager criteria reviews as meeting the clinical information requirements unless required by the Molina Healthcare Hospital or Provider Services Agreement.

Information generally required to support the decision-making process includes:

- Adequate Patient history related to the requested services
- Physical examination that addresses the area of the request
- Supporting lab and/or X-ray results to support the request
- Relevant PCP and/or Specialist progress notes or consultations

- Any other relevant information or data specific to the request

Providers who request Prior Authorization approval for Patient services and/or procedures may request to review the criteria used to make the final decision. MHSC has full-time Chief Medical Officer (CMO)/Medical Directors available to discuss medical necessity decisions with the ordering provider at (855) 237-6178.

Emergency Care

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency care services rendered to the member do not require prior authorization from MHSC.

Members accessing the emergency department inappropriately will be contacted by MHSC Case Managers whenever possible to determine the reason for using emergency services. Case Managers will also contact the PCP to ensure that members are not accessing the emergency department because of an inability to be seen by the PCP.

Prior Authorization Decision Time Frames

Pursuant to South Carolina State-established time frames, MHSC will process any non-urgent prior authorization requests no later than fourteen (14) calendar days following receipt of the request for service. Urgent requests will be processed as expeditiously as possible and within seventy-two (72) hours of receipt of the request for service.

The time frame for a non-urgent prior authorization request may be extended up to fourteen (14) calendar days if requested by the practitioner or member, if additional information is needed to make a decision, or if MHSC is unable to make a decision due to matters beyond its control. The time frame for an urgent request may be extended up to forty-eight (48) hours if requested by the practitioner, or if MHSC is unable to make a decision due to a lack of necessary information. The member, in accordance with the Medicaid contract, may request an extension up to fourteen (14) calendar days.

InPatient Management

Elective InPatient Admissions - MHSC requires prior authorization for all elective inPatient admissions to any facility. The facility is also required to provide notification of the admission within one (1) business day. Elective inPatient admission services performed without prior authorization may not be eligible for payment.

Emergent InPatient Admissions - MHSC requires notification of all emergent inPatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. MHSC requires that notification includes member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the medical necessity of the admission. Emergent inPatient admission services performed without meeting notification and medical necessity requirements will result in a denial of authorization for the inPatient admission.

NOTE: Deliveries require notification only, including the baby's full name, gender and date of birth.

Concurrent InPatient Review - MHSC performs concurrent inPatient review in order to ensure Patient safety, medical necessity of ongoing inPatient services, and adequate progress of treatment and development of appropriate discharge plans. We have streamlined the review process by increasing the timeframe between the admission and next concurrent review date. Additionally, we only request current clinical information instead of daily notes. This will allow greater focus on monitoring Patient progress and assisting with discharge planning. Our primary goal is to partner with you to ensure our members receive the highest quality care. MHSC requires that requested clinical information updates be received from the inPatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates will result in denial of authorization for the remainder of the inPatient admission. MHSC also requires that a copy of the discharge instructions, including medications and follow-up appointment information, be faxed to MHSC at (866) 423-3889 within one (1) business day of discharge.

Hospital stays of less than two (2) midnights will be reimbursed on the outPatient fee schedule.

Readmission Policy - Hospital readmissions have been found by CMS to potentially constitute a quality of care problem. Readmission review is an important part of MHSC's Quality Improvement Program to ensure that MHSC members are receiving hospital care that is compliant with nationally recognized guidelines, Medicare regulations, State Medicaid regulations and CMS.

A readmission is defined as a subsequent admission to an acute care hospital within a specified time frame of a prior admission for a related condition or as readmission is defined by State laws or regulations. The following exceptions would not constitute a readmission:

1. The readmission is determined to be due to an unrelated condition from the first inPatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission.
2. The readmission is part of a medically necessary, prior authorized or staged treatment plan.
3. There is clear medical record documentation that the Patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Non-Network Providers - MHSC maintains a contracted network of qualified healthcare professionals who have undergone a comprehensive credentialing process in order to provide medical care for MHSC members. MHSC requires members to receive medical care within the participating, contracted network of providers. All care provided by non-contracted, non-network providers must be prior authorized by MHSC. Non-network providers may provide emergent/urgent care and dialysis services for a member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State laws or regulations.

Avoiding Conflict of Interest

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

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

Continuity of Care and Transition of Members

It is MHSC's policy to provide members with advance notice when a provider they are seeing will no longer be in network. Members and providers are encouraged to use this time to transition care to an in-network provider. The provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the provider(s) assuming care. Under certain circumstances, members may be able to continue treatment with the out of network provider for a given period of time. MHSC members involved in an active course of treatment have the option to complete treatment with the provider who initiated care. The lack of a contract with the provider of a new member or terminated contracts between MHSC and a provider will not interfere with this option. This option includes members who are:

- Pregnant
- Receiving care for an acute medical condition
- Receiving care for an acute episode of a chronic condition

For each member identified in the categories above, MHSC will work with the treating provider on a transition plan over a reasonable period of time. Each case will be individualized to meet the member's needs.

Requests for continued care should be submitted to the Health Care Services Department at the phone number and address listed at the beginning of this section. All requests will be reviewed by the Chief Medical Officer (CMO)/Medical Director. MHSC typically will not approve continued care by a non-contracted provider if:

- The member only requires monitoring of a chronic condition
- The provider does not qualify for MHSC credentialing based on a previous professional review action
- The provider is unwilling to continue care for the member
- The provider has never seen the member prior to enrolling with MHSC

For additional information regarding continuity of care and transition of members, please contact MHSC at 855-237-6178.

Continuity and Coordination of Provider Communication

MHSC 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.

Coordination of Care

MHSC's Integrated Care Management, which includes Utilization Management, Case Management and Disease Management, will work with providers to assist with coordinating services and benefits for members with complex needs and issues. It is the responsibility of contracted providers to assess members and with the participation of the member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change.

MHSC staff assists providers by identifying needs and issues, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by MHSC staff is done in partnership with providers and members to ensure efforts are efficient and non-duplicative.

Case Management

MHSC provides a comprehensive Case Management (CM) program to all members with identified CM needs. The CM program focuses on member advocacy, care coordination and a collaborative process, which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet the individual's health needs throughout the continuum of care. This program is designed and in accordance with the Case Management Society of America Standards of Practice Guidelines.

The MHSC Case Managers are licensed professionals and are educated, trained and experienced in the care coordination process to empower the member to understand and access quality, efficient and cost effective healthcare.

The CM program is individualized to accommodate the member's needs. The MHSC Case Manager will collaborate with the member's providers to arrange individual services for members that may include coordination and continuity of medical care, home health care, rehabilitation services, and preventive services. The MHSC Case Manager is responsible for the assessment of the member and will communicate directly with the PCP regarding the Case Management Care Plan. The member, PCP, and/or other providers will also be invited to participate in Interdisciplinary Care Team meetings to ensure care coordination as well as continuity of care. If unable to participate, the Case Manager will communicate any recommendations from the meeting to the member and provider via telephone and written correspondence.

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

Members with the following conditions may qualify for CM and should be referred to the MHSC CM Program for evaluation:

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

Referrals to the CM Program may be made by contacting MHSC at:
Phone: (855) 237-6178
Fax: (855) 860-7197

PCP Responsibilities in Case Management Referrals

The member's PCP is the primary leader of the health team involved in the coordination and direction of services for the member. The Case Manager provides the PCP with reports, updates, and information regarding the member's progress through the CM care plan. The PCP is responsible for the provision of preventive services and for the primary medical care of members.

Case Manager Responsibilities

The Case Manager collaborates with all involved and the member to develop a plan of care which includes a multidisciplinary action plan (care plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the Case Manager, providers, and the member are responsible for implementing the plan of care. Additionally the Case Manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Coordinates appropriate education and encourages the member's role in self-help
- Monitors progress toward the member's achievement of treatment plan goals in order to determine an appropriate time for the member's discharge from the CM program

Specialty Pharmaceuticals

MHSC contracts with a specialty pharmacy services vendor to provide an innovative specialty drug delivery program. This service eliminates the costs and special storage requirements associated with stocking and billing for office administered specialty injectable drugs for MHSC members.

MHSC's specialty pharmacy vendor will coordinate with MHSC and ship the prescription directly to your office or the member's home. All packages are individually marked for each member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge.

Injectable medications that must be administered by a healthcare professional in settings such as a physician's office, infusion center, or other clinical settings are not routinely covered under Pharmacy Services (exceptions include Remicade). When billing for a provider-administered drug administered in the office, the physician must bill an injection code. A prescription for a medication that must be administered by a healthcare professional cannot be filled by a pharmacist and then returned to a physician's office for administration. Prior authorization requests for medications that must be administered by a health care professional should be submitted to the MHSC Prior Authorization team via fax at 1-866-423-3889.

Section 7. Quality Improvement

MHSC maintains a Quality Improvement (QI) Department to work with members and practitioners/providers in administering the MHSC Quality Improvement Program. You may contact the MHSC QI Department toll free at (855) 237-6178.

The address for mail requests is:

Molina Healthcare of South Carolina
Quality Improvement Department
4105 Faber Place Dr. Ste. 120
Charleston, SC 29405

This Provider Manual contains excerpts from the MHSC Quality Improvement Program (QIP). For a complete copy of MHSC's QIP that complies with regulatory and accreditation guidelines, you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

The QIP provides structure and outlines specific activities designed to improve the care, service and health of our members.

MHSC does not delegate QI activities to Medical Groups/IPAs. However, MHSC requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care and to:

- Have a quality improvement program in place
- Comply with and participate in MHSC's QI Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process
- Allow access to MHSC QI personnel for site and medical record review processes

Medical Records

MHSC conducts a review of Member's Medical Records from a representative sample of Primary Care Practitioners (PCP) of the MHSC provider network against the medical record keeping standards and requirements as well as other providers as determined necessary. This review includes the following components:

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

Practitioners/providers must demonstrate compliance with MHSC's medical record documentation guidelines. Medical records are assessed based on the following standards:

Content

- Patient name or ID is on all pages
- Current biographical data is maintained in the medical record or database
- All entries contain author identification
- All entries are dated and are indelibly documented
- Medication allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location
- Chronic conditions are listed or noted in easily recognizable location
- Past medical history
- There is appropriate notation concerning use of substances, and for Patients, there is evidence of substance abuse query

- The history and physical examination identifies appropriate subjective and objective information pertinent to a Patient's presenting complaints and provides a risk assessment of the members health status
- Consistent charting of treatment care plan
- Working diagnoses are consistent with findings
- Treatment plans are consistent with diagnoses
- Encounter notation includes follow up care, call, or return instructions
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted
- A system is in place to document telephone contacts
- Lab and other studies are ordered as appropriate
- Lab and other studies are initialed by ordering practitioner/provider upon review with lab results and other studies are filed in chart
- If Patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record
- If the practitioner/provider admitted a Patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record
- Advanced Directives are documented for those 18 years and older
- A release document for each member authorizing MHSC to release medical information for facilitation of medical care
- Developmental screenings as conducted through a standardized screening tool
- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule and all EPSDT related services
- Documentation of a pregnant member's refusal to consent to testing for HIV infection and any recommended treatment

Organization

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

Retrieval

- The medical record is available to practitioner/provider at each encounter
- The medical record is available to MHSC for purposes of quality improvement
- The medical record is available to the SCDHHS and the SCDHHS's External Quality Review Organization upon request
- The medical record is available to the member upon their request
- Medical record retention process is consistent with state and federal requirements
- An established and functional data recovery procedure in the event of data loss

Confidentiality

- 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

If you have any questions regarding this information, please contact the MHSC's QI Department toll free at (855) 237-6178. You can also refer to Section 16 (HIPAA/Security) for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Monitoring Access Standards

MHSC monitors compliance with the established access standards. At least annually, MHSC conducts an audit of randomly selected contracted practitioner/provider offices to determine if appointment access standards are met. One or all of the following appointment scenarios may be addressed: routine care, acute care,preventive care, and after-hours information. Results of the audit are distributed to the practitioners after its completion. A corrective action plan may be required if standards are not met.

In addition, MHSC's Member Services Department reviews member inquiry logs and grievances related to delays in access to care. These are reported quarterly to Peer Review and Credentialing Committee. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Advance Directives (Patient Self-Determination Act)

Advance Directives

Practitioners/providers must inform adult MHSC members (18 years old and up) of their right to make health care decisions and execute advance directives. It is important that members are informed about advance directives. During routine Medical Record review, MHSC auditors will look for documented evidence of discussion between the practitioner/provider and the member. MHSC 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.

Each MHSC practitioner/provider must honor advance directives to the fullest extent permitted under law. Members may select a new PCP if the assigned provider has an objection to the beneficiary's desired decision. MHSC will facilitate finding a new PCP or specialist as needed.

PCPs must discuss advance directives with a member and provide appropriate medical advice if the member desires guidance or assistance. MHSC's network practitioners and facilities are expected to communicate any objections they may have to a member directive prior to service whenever possible. In no event may any practitioner/provider refuse to treat a member or otherwise discriminate against a member because the member has completed an advance directive. Members have the right to file a grievance with MHSC or the state survey and certification agency if the member is dissatisfied with MHSC's handling of advance directives and/or if a practitioner/provider fails to comply with advance directives instructions.

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

Advance directives completed prior to the establishment of the current combined form are still valid. Advance directives that were executed in another state, using another state's form are also valid.

When There Is No Advance Directive: The member's family and practitioner 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.

EPSDT Services to Enrollees Under Twenty-One (21) Years

MHSC maintains systematic and robust monitoring mechanisms to ensure all required EPSDT services to enrollees under twenty-one (21) years of age are timely according to required guidelines. All enrollees under twenty-one (21) years of age should receive

screening examinations including appropriate childhood immunizations at intervals as specified by the EPSDT Program as set forth in §§1902(a)(43)and 1905(a)(4)(B) of the Social Security Act and 89 Ill. Adm. Code 140.485. Children under three (3) years of age, who are screened at-risk for, or with developmental delay, must be referred to SCDHHS's Early Intervention Program for further assessment. MHSC's QI Department is also available to perform provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child / Adolescent Visits

Visits consist of age appropriate components including but not limited to:

- Comprehensive health history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Immunizations
- Laboratory procedures, including lead toxicity testing
- Periodic objective developmental screening using a recognized, standardized developmental screening tool, as approved by SCDHHS
- Objective vision and hearing screening
- Risk assessment
- Anticipatory guidance
- Periodic objective screening for social, emotional, development using a recognized, standardized tool, as approved by SCDHHSPerinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, behavioral health or OB/GYN visit

Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the member's Covered Benefit Services. Members will be referred to an appropriate source of care for any required services that are not Covered Services. If, as a result of EPSDT services, it is determined that the member is in need of services that are not Covered Services but are services otherwise provided for under the SCDHHS Program, MHSC will ensure that the member is referred to an appropriate source of care. MHSC shall have no obligation to pay for services that are not Covered Services.

Monitoring for Compliance with Standards

MHSC 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 MHSC's standards may result in a corrective action plan (CAP) with a request the Provider submit a written corrective action plan to MHSC within (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the provider are included in the providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new members.

Quality Improvement Activities and Programs

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

Clinical Practice Guidelines, Behavioral Health Guidelines, and Preventive Health Guidelines

1. Clinical Practice Guidelines (CPG) and Behavioral Health Guidelines (BHG) – MHSC CPGs and BHGs are evidence-based practice guidelines based upon scientific evidence, published medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost considerations. The recommendations for care are suggested guides for making clinical and behavioral

decisions and intended to optimize the Patient's care. Providers and Patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each Patient.

MHSC's Clinical Practice Guidelines are as followed:

- Asthma
- Cardiovascular Risk
- Cholesterol
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Sickle Cell Disease
- Upper Respiratory Tract Infections

MHSC's Behavioral Health Guidelines are as follows:

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Depression
- Substance Use Disorder

2. Preventive Health Guidelines (PHG) - MHSC PHGs are national recommendations that help providers to work along with their Patients to stay on track with necessary screenings and exams based on age and gender. MHSC provides coverage of diagnostic preventive procedures based on recommendations published by the Institute for Clinical Systems Improvement (ICSI) and the Centers for Disease Control and Prevention (CDC).

   MHSC's Preventive Health Guidelines are as follows:

   - Adults
   - Children and Adolescent
   - Prenatal Care, Routine

   MHSC reviews and revises all guidelines at least every two (2) years. Individual providers or members may request copies of the guidelines by calling the Member Services Department toll free at (855)735-5831 or visit MHSC website: http://www.molinahealthcare.com/providers/sc/medicaid/resource/Pages/clinical.aspx

Cultural Competency Plan

Background

The Cultural Competency Plan exists to ensure the delivery of culturally competent services and ensure the provision of Linguistic Access and Disability-related Access to all members including those with limited English proficiency. The plan is based on guidelines outlined in National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH). The Cultural Competency Plan describes how the individuals and systems within the Organization will effectively provide services to people of all cultures, races, ethnic backgrounds and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Training of employees and providers, and quality monitoring are the cornerstones of successful culturally competent service delivery. For that reason, the Cultural Competency Program is integrated into the overall provider training and quality monitoring programs.

An integrated quality approach is aimed at enhancing 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

MHSC offers educational opportunities in cultural competency concepts for providers on a regular basis. This is a summary of the Cultural Competency Plan; providers may use links on the MHSC website to obtain the full Cultural Competency Plan. Cultural Competency trainings are offered to providers and supporting staff. Cultural Competency Training programs are also available to Community Based Organizations.

Provider training is conducted concurrent with and integrated into provider orientation with annual reinforcement training. Additional training reinforcement is provided through continuing medical education (CME) monographs developed by the health plan, and periodically accompanying provider communications. Cultural Notes, a monthly newsletter publication, is emailed to interested providers highlighting important cultural customs relevant to plan members.

Training is provided in modules delivered through a variety of methods including, but not limited to, one or more of the following:

1. Written materials – Provider Manual
2. Access to enduring reference materials available through health plan representatives and the MHSC website
3. Integration of cultural competency concepts into provider communications
4. Continuing Medical Education

Integrated Quality Improvement – Ensuring Access

MHSC ensures member access to language services such as oral interpreting, written translation and access to programs and services that are congruent with cultural norms and provide quality care.

MHSC provides oral interpreting of written information to any plan member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. MHSC notifies plan members of the availability of oral interpreting services and informs them of how to access oral interpreting services. Members are informed that there is no charge for interpreting and translation services.

Members may also request written member materials in alternate languages and formats, which are provided within fourteen (14) business days. Such congruency with member populations leads to better communication, understanding and member satisfaction. Key member information, including Appeals and Grievance forms, are also available in threshold languages on the Molina Healthcare member website.

Program and Policy Review Guidelines

MHSC conducts assessments at regular intervals of the following information in order to ensure its programs are most effectively meeting the needs of its members and providers:

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment)
- Network Assessment
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS as available comparison with selected measures such as those in Healthy People 2020

Cultural and Linguistic Services

MHSC serves a diverse population of members with specific cultural needs and preferences. Practitioners/providers are responsible to ensure that interpreter services are made available at no cost for members with sensory impairment and/or who are Limited

English Proficient (LEP). The following cultural and linguistic services are offered by MHSC to assist both members and practitioners/providers.

24 Hour Access to Interpreter

Practitioners/providers may request interpreters for members whose primary language is other than English by calling MHSC's Member Services Department toll free at (855) 882-3901. If Member Services Representatives are unable to provide the interpretation services internally, the member and practitioner/provider are immediately connected to Language Line telephonic interpreter service.

If a Patient insists on using a family member as an interpreter after being notified of his or her right to have a qualified interpreter at no cost, document this in the member's medical record. MHSC is available to assist you in notifying members of their right to an interpreter. All counseling and treatment done via an interpreter should be noted in the medical record by stating that such counseling and treatment was done via interpreter services. Practitioners/providers should document who provided the interpretation service. That information could be the name of their internal staff or someone from a commercial vendor such as Language Line. Information should include the interpreter's name, operator code number and vendor.

Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

MHSC's most recent results can be obtained from the MHSC QI Department toll free at (855) 237-6178.
Contracted providers and facilities must allow MHSC 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.

HEDIS®

MHSC 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, pre-natal visits, diabetes care, and cardiovascular disease.

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

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.

CAHPS®

CAHPS® is the tool used by MHSC to summarize member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including: getting needed care, getting care quickly, how well doctors communicate, health promotion and education and coordination of care and customer service. 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 MHSC's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® both focus on member experience with health care practitioners/providers and health plans, MHSC conducts a Provider Satisfaction Survey annually. The results from this survey are very important to MHSC, as this is one of the primary methods we use to identify improvement areas pertaining to the MHSC Provider Network. The survey results have helped establish improvement activities relating to MHSC's specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of practitioners/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

MHSC 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.

Section 8. Claims and Provider Payments

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

- Claim Submission
- Corrected Claim
- Claims Disputes/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Billing The Member

Claim Submission

Claims may be submitted to MHSC with appropriate documentation by mail or filed electronically (EDI) for CMS-1500 and UB-04 claims. For members assigned to a delegated medical group/IPA that processes its own claims, please verify the "Remit To" address on the member's MHSC ID card (Refer to Section 2). Providers billing MHSC directly should send claims to:

Molina Healthcare of South Carolina
PO Box 22664
Long Beach, CA 90801

Providers billing MHSC electronically should use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims) and use electronic payor ID number: 46299.

Providers must use good faith effort to bill MHSC 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. The following information must be included on every claim:

- Institutional Providers:
    - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC),

submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statue and regulations and any state designated data requirements included in statues or regulation.

- Physicians and Other Professional Providers:
  - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries stated as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.

National Provider Identifier (NPI)

Providers must report any changes in their NPI or subparts to MHSC within thirty (30) calendar days of the change.

Documents that do not meet the criteria described above may result in the claim being denied or returned to the provider. Claims must be submitted on the proper claim form, either a CMS-1500 or UB-04. MHSC will only process legible claims received on the proper claim form containing the essential data requirements. Incomplete, inaccurate, or untimely re-submissions may result in denial of the claim.

Electronic Claim Submissions

MHSC also accepts electronic claim submissions for both claims and encounters using the CMS-1500 and UB-04 claim types. Please use MHSC's Electronic Payor ID number – 46299. 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 electronically:

- You should receive an acknowledgement from your current clearinghouse
- You should receive an acknowledgement from Emdeon within two (2) business days of your transmission
- You should contact your local clearinghouse representative if you experience any problems with your transmission
- For any direct submissions to MHSC, you should receive an acknowledgement of your transmission

Timely Claim Filing

Provider shall promptly submit to MHSC claims for Covered Services rendered to members. All claims shall be submitted in a form acceptable to and approved by MHSC, and shall include any and all medical records pertaining to the claim if requested by MHSC or otherwise required by MHSC's policies and procedures. Claims must be submitted by provider to MHSC within twelve (12) months/three hundred and sixty-five (365) days after the following have occurred: discharge for inPatient services or the date of service for outPatient services; and provider has been furnished with the correct name and address of the member's health maintenance organization. If MHSC is not the primary payer under coordination of benefits, provider must submit claims to MHSC within twelve (12) months/three hundred and sixty-five (365) days from date of service after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to MHSC within these timelines shall not be eligible for payment, and provider hereby waives any right to payment therefore.

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 Fraud and Abuse section of this manual for more information.

Timely Claim Processing

Claims payment will be made to contracted providers in accordance with the timeliness provisions set forth in the provider's contract. Unless the provider and MHSC or contracted medical group/IPA have agreed in writing to an alternate payment schedule, MHSC will pay the provider of service within thirty (30) calendar days after receipt of clean claims.

The receipt date of a claim is the date MHSC receives either written or electronic notice of the claim.

Claim Editing Process

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

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

Coding edits are generally based on state fee for service Medicaid edits, AMA, Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative (NCCI) guidelines. If you disagree with an edit, please refer to the Claim Disputes/Adjustments section below.

Coordination of Benefits and Third Party Liability

COB

Medicaid is the payor of last resort. Private and governmental carriers must be billed prior to billing MHSC or medical groups/IPAs. Provider shall make reasonable inquiry of members to learn whether member has other health insurance which may include benefits or covered services that would pay before MHSC. Provider shall immediately notify MHSC of said entitlement. In the event that coordination of benefits occurs, provider shall be compensated in an amount equal to the allowable clean claim less the amount paid by other health plans, insurance carriers and payers, not to exceed MHSC's contracted allowable rate. The provider must include a copy of the other insurance's EOB with the claim.

Third Party Liability

MHSC will pay claims for covered services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a claim. MHSC will attempt to recover any third-party resources available to members and shall maintain records pertaining to TPL collections on behalf of members for audit and review.

Claims Disputes/Adjustments

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) calendar days of MHSC's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following documentation:

- The item(s) being resubmitted should be clearly marked as a Claim Dispute/ Adjustment
- Payment adjustment requests must be fully explained
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/ Authorization form (if applicable) must accompany the adjustment request
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following address:

Molina Healthcare of South Carolina
Attention: Claims Disputes / Adjustments
4105 Faber Place Dr. Ste. 120
Charleston, SC 29405

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

The provider will be notified of MHSC's decision in writing within thirty (30) calendar days of receipt of the Claims Dispute/Adjustment request. A provider Appeal on behalf of a member for claims in which services were denied, which differs from "Provider Dispute/Adjustment" request, must be submitted within thirty (30) calendar days of the original RA from MHSC in order to be considered. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Corrected Claims

Corrected claims are considered new claims. Corrected claims may be submitted electronically with the appropriate field on the 837 I or 837 P completed. Paper corrected claims need to be marked as corrected and should be submitted to the following address:

Molina Healthcare of South Carolina
PO Box 22664
Long Beach, CA 90801

Overpayments and Incorrect Payments Refund Requests

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

A provider shall pay a claim for an overpayment made by MHSC which the provider does not contest or deny within the specified number of days on the refund request letter mailed to the provider.

All correspondence, including disputes/Appeals regarding recoveries should be sent to:

Molina Healthcare of South Carolina
PO Box 2470 Spokane, WA 99210-2470

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment.

Billing the Member

MHSC contracted providers may not bill the member for any covered benefit. The contract between the provider and MHSC places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider.

Encounter Data

Each capitated provider/organization delegated for claims payment is required to submit encounter data to MHSC for all adjudicated claims. The data is used for many purposes, such as reporting to HFS, rate setting and risk adjustment, hospital rate setting, the QIP and HEDIS® reporting.

Encounter data must be submitted once per month, and must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with claims level detail for all non-institutional services provided. For institutional services, only those services covered by MHSC should be reported.

MHSC shall have a comprehensive automated and integrated encounter data system capable of meeting these requirements.

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

Section 9. Fraud and Abuse

Introduction

MHSC maintains a comprehensive Fraud, Waste, and Abuse program. MHSC is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. Molina's Special Investigation Unit supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with MHSC and/or those serving our members.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. Government for payment.

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

- Has actual knowledge of falsity of information in the claim
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or Acts in reckless disregard of the truth or falsity of the information in a claim

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

Deficit Reduction Act

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

Healthcare entities like MHSC who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with MHSC, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims
- How providers will detect and prevent fraud, waste, and abuse
- Employee protection rights as a whistleblowers

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

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

- Employment reinstatement at the same level of seniority

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

Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. MHSC will take steps to monitor MHSC contracted providers to ensure compliance with the law.

Definitions

Fraud:

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

Waste:

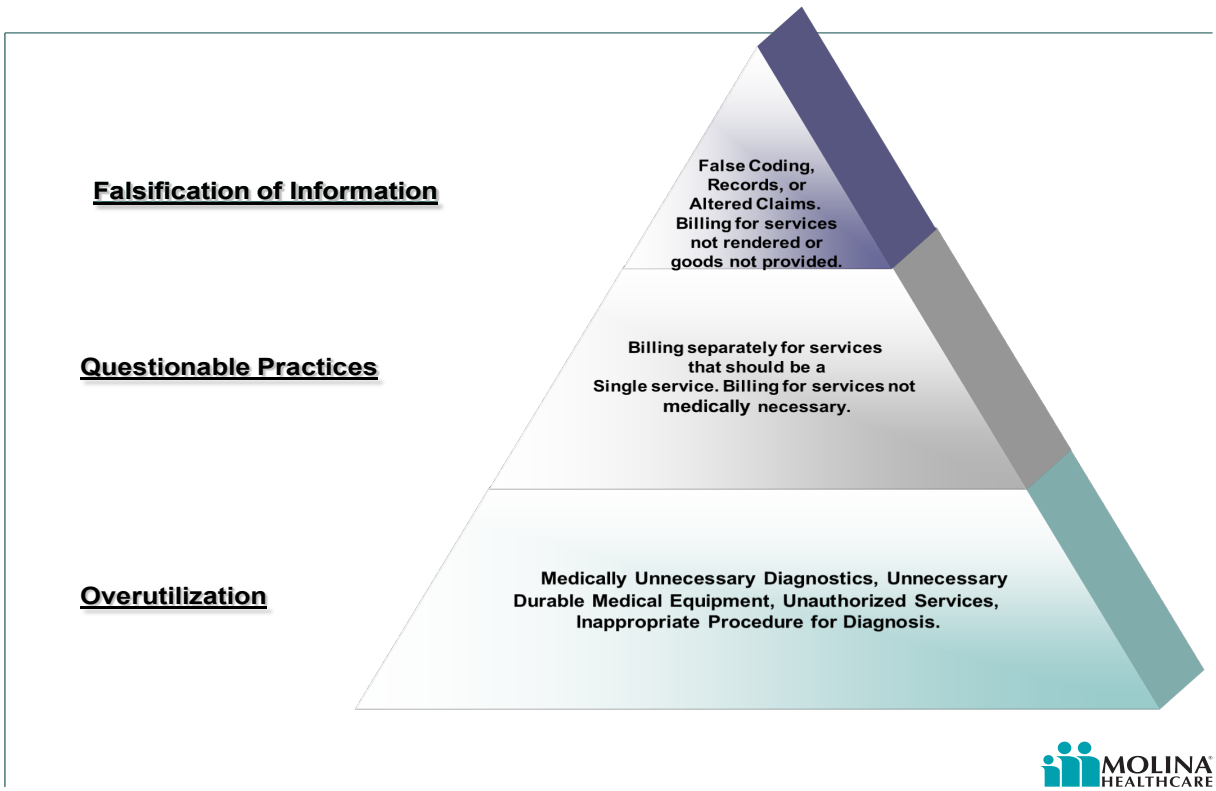
Health care spending that can be eliminated without reducing the quality of care. Quality Waste includes overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

Abuse:

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

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered
- Providing services to Patients that are not medically necessary
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the Patient to pay the difference between the discounted fees, negotiated fees, and the provider's usual and customary fees
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, "unbundling" of procedures, non-covered treatments to receive payment, "up-coding", and billing for services not provided
- Concealing Patients misuse of MHSC identification card
- Failure to report a Patient's forgery/alteration of a prescription
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid Patients
- A physician knowingly and willfully referring Medicaid Patients to health care facilities in which or with which the physician has a financial relationship (The Stark Law)



Review of Provider

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

- Federal and State Medicaid sanction reports
- Federal and State lists of excluded individuals and entities including the South Carolina Excluded Providers Spreadsheet located at https://www.scdhhs.gov/provider
- List of parties excluded from Federal Procurement and Non-procurement Programs
- Medicaid suspended and ineligible provider list
- Monthly review of each state Medical Board sanctions list
- Review of license reports from the appropriate specialty board

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

Provider Profiling

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

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

Provider/Practitioner Education

When MHSC identifies through an audit, provider profile or other means a situation with a provider (e.g. coding, billing) that is either inappropriate or deficient, the Compliance Officer may determine that a provider/practitioner education visit is appropriate.

The Compliance Department and/or the Special Investigation Unit will contact the provider/practitioner's MHSC Provider Services Representative regarding the education issue. The Provider Services Representative will be informed that an on-site meeting at the provider's office is required in order to educate the provider on certain issues identified as inappropriate or deficient.

Review of Provider Claims and Claims System

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

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

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

Cooperating with Special Investigation Unit Activities

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

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by Global Compliance, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available twenty-four (24) hours a day/seven (7) days a week, three hundred sixty-five (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 Global Compliance will note your concerns and provide them to the Molina Healthcare Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

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

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

Molina Healthcare of South Carolina
Attn: Compliance
4105 Faber Place Dr., Suite 120
Charleston, South Carolina 29405

Remember to include the following information when reporting:

- Nature of complaint

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

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

South Carolina Department of Health and Human Services
Medicaid Fraud and Abuse Hotline
Toll Free Phone: (888) 364-3224

South Carolina Attorney General
Medicaid Fraud Unit
By Phone: (803) 734-3660 or Toll Free (888) 662-4325

Section 10. Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the MHSC network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of MHSC to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary source verification, recommendation of peer Providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, MHSC Members will not be referred and/or assigned to you until the credentialing process has been completed.

Criteria for Participation in the MHSC Network

MHSC has established criteria and the sources used to verify these criteria for the evaluation and selection of Providers for participation in the MHSC network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the MHSC network.

To remain eligible for participation, Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by MHSC.

MHSC reserves the right to exercise discretion in applying any criteria and to exclude Providers who do not meet the criteria. MHSC may, after considering the recommendations of the Peer Review and Credentialing Committee waive some of the requirements for network participation established pursuant to these policies for good cause, if determined that such waiver is necessary to meet the needs of MHSC and the community it serves. MHSC will not waive some state or federally mandated requirement for network participation. The refusal of MHSC to waive any requirement shall not entitle any Provider to a hearing or any other rights of review. MHSC will abide by all state and federal mandated requirements for provider participation
.
Providers must meet the following criteria to be eligible to participate in the MHSC network. If the Provider fails to meet/provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial from the MHSC network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal. The initial credentialing denial does not get reported to NPDB.

1. Provider must practice, or plan to practice within 90 calendar days, within the area served by MHSC.
2. All Providers, including ancillary Providers, (i.e. vision, pharmacy, etc.), will apply for enrollment in the Medicaid program. Providers are required to have an NPI or an Administrative Provider Identification Number (APIN).
3. Provider must complete and submit to MHSC a credentialing application. The application must be entirely complete. The Provider must sign and date that application attesting that their application is complete and correct within 180 calendar days of the credentialing decision. If MHSC or the Peer Review and Credentialing Committee request any additional information or clarification the Provider must supply that information in the time-frame requested.

4. Provider must have and maintain a current, valid license to practice in their specialty in every state in which they will provide care for MHSC Members.
5. If applicable to the specialty, Provider must hold a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration. If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS, the Provider may be considered for network participation if they submit a written prescription plan describing the process for allowing another Provider with a valid DEA or CDS certificate to write all prescriptions. If a Provider does not have a DEA because of disciplinary action, including but not limited to being revoked or relinquished, the Provider is not eligible to participate in the MHSC network.
6. If a Provider indicates on their credentialing application they provide laboratory services at their practice location(s), the Clinical Laboratory Improvement Amendment (CLIA) Certificate must be verified directly with Centers for Medicare and Medicaid Services (CMS). All providers billing laboratory procedures must hold and maintain a Clinical Laboratory Improvement Amendment (CLIA) Certificate at the time of credentialing.
7. Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore Providers must confine their practice to their credentialed area of practice when providing services to MHSC Members.
8. Providers must have graduated from an accredited school with a degree required to practice in their specialty.
9. Oral Surgeons and Physicians (MDs, DOs) must have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. MHSC only recognizes 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) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
10. Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not Board Certified may be considered for participation only if they have satisfactorily completed a training program from an accredited training program in the specialty in which they are practicing. MHSC recognizes Board Certification only from the following Boards:
    a. American Board of Medical Specialties (ABMS)
    b. American Osteopathic Association (AOA)
    c. American Board of Podiatric Surgery (ABPS)
    d. American Board of Podiatric Medicine (ABPM)
    e. American Board of Oral and Maxillofacial Surgery
11. Providers 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 Provider in the MHSC network. To be eligible, the Provider 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.
12. Provider must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the Provider has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse practitioner, clinical social worker) within the 5-years should be included. If MHSC determines there is a gap in work history exceeding six-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If MHSC determines there is a gap in work history that exceeds one-year, the Provider must clarify the gap in writing.
13. Providers must supply a full history of malpractice and professional liability Claims and settlement history. Documentation of malpractice and professional liability Claims and settlement history is requested from the Provider 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 Provider.
14. Provider must disclose a full history of all license actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily 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 Provider.

15. At the time of initial application, the Provider 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.
16. Provider must disclose all Medicare and Medicaid sanctions. Provider 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 Provider.
17. Provider 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.
18. Provider must have and maintain professional malpractice liability insurance with coverage limits that meet MHSC criteria specifically outlined in Addendum B of this policy. This coverage shall extend to MHSC Members and the Provider's activities on MHSC's behalf.
19. Provider must disclose any inability to perform essential functions of a Provider 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 Provider.
20. Provider must disclose if they are currently using any illegal drugs/substances. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program.
21. Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
22. Provider must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, Patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
23. Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.
24. Physicians (MD, DO), Primary Care Providers, Oral Surgeons, Podiatrists and/or those Providers dictated by state Law, must have admitting privileges in their specialty. If a Provider chooses not to have admitting privileges, the Provider may be considered for network participation if they have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed MHSC participating Provider that has the ability to admit MHSC Patients to a hospital. Providers practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Psychiatry, Sleep Medicine, Sports Medicine, Telemedicine, Urgent Care and Wound Management do not require admitting privileges.
25. Providers not able to practice independently according to state law must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with MHSC.
26. Providers currently listed on the Medicare Opt-Out Report may not participate in the MHSC network for any Medicare line of business.
27. If applicable to the specialty, Provider must have a plan for shared call coverage that includes 24-hours a day, seven

[1] If a Provider's application is denied solely because a Provider 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 Provider 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.

days per week and 365 days per year. The covering Provider(s) must be qualified to assess over the phone if a Patient should immediately seek medical attention or if the Patient can wait to be seen on the next business day. All Primary Care Providers must have 24-hour coverage. Physicians practicing in Dermatology, Occupational Medicine, Pain Medicine, Physical Medicine and Rehabilitation, Sleep Medicine, Telemedicine, Sports Medicine, Urgent Care and Wound Management are not required to have 24-hour coverage.

28. MHSC may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied from network participation by MHSC, who is currently in the Fair Hearing Process, or who is under investigation by MHSC. MHSC also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied from network participation by MHSC. For purposes of the criteria, a company is "owned" by a Provider when the Provider has at least 5% financial interest in the company, through shares or other means.
29. Providers denied by the Peer Review and Credentialing Committee are not eligible to reapply until one year after the date of denial by Peer Review and Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation outlined above.
30. Providers terminated by the Peer Review and Credentialing Committee or terminated from the network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation as outlined above.
31. Providers denied are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation above.
32. Providers requesting to practice in Pain Management, must have satisfactorily completed a training program from an accredited training program in the specialty of Pain Management, Anesthesiology or Physical Medicine & Rehabilitation or currently be board certified in one of these specialties.
33. Nurse Practitioners must have a current, valid license to practice as a Nurse Practitioner in every state in which they will provide care for MHSC Members. They must have and maintain a Supervising Physician who is contracted with MHSC with an active South Carolina license. This formal relationship will be authenticated by MHSC. The Nurse Practitioner must have and maintain admitting hospital privileges or formal plan for hospital admissions. Nurse Practitioner must submit approved written protocols which include specific statements developed collaboratively between the Supervising Physician and the Nurse Practitioner that establishes physician delegation for medical aspects of care, including the prescription of medications. The written protocols must include:
    a) Name, address, and current South Carolina license number of the Nurse Practitioner
    b) Name, address, and current South Carolina license number of the Supervising Physician
    c) Nature of practice and practice locations of the Nurse and Supervising Physician
    d) Date the protocol was developed and dates the protocol was reviewed and amended. The last review date must be within the past 12-months. The protocol must include the signature of both the Nurse and the Supervising Physician
    e) Description of how consultation with the Supervising Physician is provided and provision for backup consultation in the physician's absence
    f) The medical conditions for which therapies may be initiated, continued, or modified
    g) The treatments that may be initiated, continued, or modified
    h) The drug therapies that may be prescribed
    i) Situations that require direct evaluation by or referral to the Supervising Physician

Burden of Proof

The Provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the MHSC network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a Provider without limitation, including physical and mental health status as allowed by Law, and the burden of resolving any doubts about these or any other qualifications to participate in the MHSC network.

If the Provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the MHSC network. Practitioners who fail to provide this burden of proof do not have the right to submit an Appeal.

Provider Termination and Reinstatement

If a Provider's contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement, if there is a break in service more than thirty (30) calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Peer Review & Credentialing Committee's review must be re-verified. The Peer Review and Credentialing Committee Peer Review and Credentialing Committee or Chief Medical Officer (CMO)/Medical Director, as appropriate, must review all credentials and make a final determination prior to the practitioner's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than thirty (30) calendar days, the practitioner can be reinstated without being initially credentialed.

If MHSC is unable to recredential a Provider within thirty-six (36) months because the Provider is on active military assignment, maternity leave or sabbatical but the contract between MHSC and the Provider remains in place, MHSC will recredential the Provider upon his or her return. MHSC will document the reason for the delay in the Provider's file. At a minimum, MHSC will verify that a Provider who returns has a valid license to practice before he or she can resume seeing Patients. Within sixty (60) calendar days of notice when the Provider resumes practice, MHSC will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than thirty (30) calendar days, MHSC will initially credential the Provider before the Provider rejoins the network.

Providers Terminating with a Delegate and Contracting with Molina Directly

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with MHSC or wish to contract with MHSC directly must be credentialed by MHSC within six (6) months of the Provider's termination with the delegate. If the Provider has a break in service more than thirty (30) calendar days, the Provider must be initially credentialed prior to reinstatement.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide MHSC with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider must attest that their application is complete and correct within one hundred eighty (180) calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. MHSC may use another organization's application as long as it meets all the factors outlined in this policy. MHSC will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The attestation must include, unless state law requires otherwise:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage
- The correctness and completeness of the application

Inability to Perform Essential Functions and Illegal Drug Use

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Providers may use language other than "drug" to attest they are not presently using illegal substances. MHSC may accept more general or extensive language to query Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

History of Actions against Applicant

An application must contain the following information, unless state law requires otherwise:

- History of loss of license
- History of felony convictions
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a Provider has had privileges
- History of Medicare and Medicaid Sanctions

Current Malpractice Coverage

The application form must include specific questions regarding the dates and amount of a Provider's current malpractice insurance. MHSC may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the For Providers with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Provider files that include a copy of the federal tort letter or an attestation from the Provider of federal tort coverage are acceptable.

Correctness and Completeness of the Application

Provider must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to MHSC is used, it must include an attestation to the correctness and completeness of the application. MHSC does not consider the associated attestation elements as present if the Provider did not attest to the application within the required time frame of one hundred eighty (180) days. If state regulations require MHSC to use a credentialing application that does not contain an attestation, MHSC must attach an addendum to the application for attestation.

Meeting Application Time Limits

If the Provider attestation exceeds one hundred eighty (180) days before the credentialing decision, the Provider must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the Provider to update the attestation.
The Process for Making Credentialing Decisions

All Providers requesting initial participation with MHSC must complete a credentialing application. To be eligible to submit an application, Providers must meet all the criteria outlined above in the section titled "Criteria for Participation in the MHSC Network". Providers requesting initial credentialing may not provide care to MHSC Members until the credentialing process is complete and final decision is rendered.

MHSC recredentials its Providers at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, a request will be sent to the Provider requesting completion of a recredentialing application.

During the initial and recredentialing application process, the Provider must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last one hundred eighty (180) calendar days
- Provide MHSC adequate information to prove he/she meets all criteria for initial participation or continued participation in the MHSC network

Once the application is received, MHSC will complete all the verifications as outlined in the MHSC Credentialing Program Policy. In order for the application to be deemed complete, the Provider must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the MHSC network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by MHSC must be provided.

If the Provider does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and MHSC will discontinue processing of the application. This will result in an administrative denial or termination from the MHSC network. Providers who fail to provide proof of meeting the criteria or fail to provide a complete

credentialing application do not have the right to submit an Appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Chief Medical Officer (CMO)/Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the MHSC Peer Review & Credentialing Committee.

At each Peer Review and Credentialing Committee meeting, Provider credentialing files assigned a Level 2 are reviewed by Peer Review and Credentialing Committee. All of the issues are presented to the Peer Review and Credentialing Committee Members and then open discussion of the issues commences. After the discussion, the Peer Review and Credentialing Committee votes for a final recommendation. The Peer Review and Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information. Providers whose initial credentialing applications are denied do not have the right to submit an Appeal.

Process for Delegating Credentialing and Recredentialing

MHSC will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet MHSC's requirements for delegation. MHSC's Delegation Oversight Committee (DOC) must approve all delegation and sub delegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet MHSC's requirements.

MHSC's Peer Review and Credentialing Committee always retains the right to approve new Providers and Provider sites and terminate Providers, Providers and sites of care based on requirements in MHSC's Credentialing Program Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass MHSC's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and SCDHHS regulations and requirements, with a score of at least 90%
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by MHSC at pre-assessment
- Agree to MHSC's contract terms and conditions for credentialing delegates
- Submit timely and complete reports to MHSC as described in policy and procedure
- Comply with all applicable federal and state laws including SCDHHS regulations and requirements
- If the IPA or Provider Group sub delegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation

- MHSC may also choose to sub delegate the primary source verification process to a Centralized Verification Organization (CVO). In order to be delegated, the CVO must:
  - Be certified by the National Committee for Quality Assurance (NCQA) in all ten areas of credentialing accreditation
  - Pass MHSC's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and SCDHHS regulations and requirements, with a score of at least 90%
  - Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by MHSC at pre-assessment
  - Agree to MHSC's contract terms and conditions for credentialing delegates
  - Submit timely and complete reports to MHSC as described in policy and procedure
  - Comply with all applicable federal and state laws including SCDHHS regulations and requirements
- Prior to finalizing the delegation of any credentialing function, MHSC obtains written approval from South Carolina Department of Health and Human Services (SCDHHS). If the IPA/Provider Group sub delegates any portion of the credentialing process, MHSC will also obtain written approval from South Carolina Department of Health and Human Services (SCDHHS) prior to finalizing the delegation.

Non-Discriminatory Credentialing and Recredentialing

MHSC does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or Patients (e.g. Medicaid or Medicare) in which the Provider specializes. This does not preclude MHSC from including in its network Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

Notification of Discrepancies in Credentialing Information

MHSC will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided bvy the Provider. Examples include, but are not limited to, actions on a license; malpractice claims history or sanctions MHSC 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. Please also refer to the section below titled Providers Right to Correct Erroneous Information.

Notification of Credentialing Decisions

A letter is sent to every Provider with notification of the Peer Review and Credentialing Committee or Chief Medical Officer (CMO)/ Medical Director decision regarding their participation in the MHSC network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the Provider's credentials files. Under no circumstance will notification letters be sent to the Providers later than sixty (60) calendar days from the decision.

Confidentiality and Immunity

Information regarding any Provider or Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective Patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under this Policy and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to perform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective Patient care. For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a Practitioner's or Provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect Patient care or Provider's or Provider's provision of Patient care services.

By providing Patient care services at MHSC, a Provider:

1. Authorizes representatives of MHSC to solicit, provide, and act upon information bearing on the Provider's or Provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, MHSC membership and the continuation of such membership, and to the exercise of clinical privileges or provision of Patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but not limited to:

1. Any type of application or reapplication received by the Provider.
2. Actions reducing, suspending, terminating or revoking a Provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action.
3. Hearing and appellate review.

4. Peer review and utilization and quality management activities.
5. Risk management activities and claims review.
6. Potential or actual liability exposure issues.
7. Incident and/or investigative reports.
8. Claims review.
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board.
10. Any activities related to monitoring the quality, appropriateness or safety of health care services.
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services.
12. Any MHSC operations and actions relating to Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state and federal Law, and are not a limitation thereof.

All Members (voting and non-voting) and guests of the Peer Review and Credentialing Committee , or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Peer Review and Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at MHSC.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by Law. Access to these documents are restricted to authorized staff, Peer Review and Credentialing Committee Members, peer reviewers and reporting bodies as authorized by the Peer Review and Credentialing Committee or the Governing Board of MHSC. Each person is given a unique user ID and password. It is the strict policy of MHSC that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three (3) months.

Minutes, reports and files of Peer Review and Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable Laws.

Copies of minutes and any other related Peer Review and Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and MHSC Staff is instructed not to divulge passwords to their co-workers.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The Provider 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 Chief Medical Officer (CMO)/Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Provider 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 Provider are documents which the Provider sent to MHSC (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Licensing Board), and verification of hospital privileges letters.

Practitioners Right to Correct Erroneous Information

Providers have the right to correct erroneous information in their credentials file. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

MHSC will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include, but are not limited to, actions on a license or malpractice claims history. MHSC 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.

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

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

Upon receipt of notification from the Provider, MHSC will document receipt of the information in the Provider's credentials file. MHSC will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Provider's credentials file. The Provider will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with Providers', the Credentialing Department will notify the Provider. The Provider may then provide proof of correction by the primary source body to MHSC's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the Provider does not respond within ten (10) calendar days, their application processing will be discontinued and network participation will be denied.

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application. Providers applying for initial participation are sent a letter when their application is received by MHSC and are notified of their right to be informed of the status of their application in this letter.

The Provider can request to be informed of the status of their application by telephone, email or mail. MHSC will respond to the request within two (2) working days. MHSC may share with the Provider where the application is in the credentialing process to include any missing information or information not yet verified. MHSC does not share with or allow a Provider to review references or recommendations, or other information that is peer-review protected.

Peer Review and Credentialing Committee (PRC)

MHSC designates a Peer Review and Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. MHSC works with the Peer Review and Credentialing Committee to strive to assure that network Providers are competent and qualified to provide continuous quality care to MHSC Members. A Provider may not provide care to MHSC Members until the credentialing process is complete and the final decision has been rendered.

The Peer Review and Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant Providers and for making recommendations regarding their participation in the MHSC network. In addition, the Peer Review and Credentialing Committee reviews Credentialing Policies and Procedures annually and recommend revisions, additions and/or deletions to the policies and procedures. Composed of network Providers, the committee is responsible for performing peer review of medical information when requested by the Chief Medical Officer (CMO)/Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Peer Review and Credentialing Committee Member shall be immune, to the fullest extent provided by Law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Chief Medical Officer (CMO)/Medical Director chair the Peer Review and Credentialing Committee and appoint all Peer Review and Credentialing Committee Members. Each Member is required to meet all of MHSC's credentialing criteria. Peer Review and Credentialing Committee members must be current representatives of MHSC's Provider network. The Peer Review and Credentialing Committee representation includes at least five practitioners. These may include Providers from the following specialties:

- Behavioral Health
- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc Providers may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Provider, Nurse Practitioners, and Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Peer Review and Credentialing Committee.

Peer Review and Credentialing Committee Members Roles and Responsibilities

- Committee Members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by MHSC on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements. The Peer Review and Credentialing Committee votes to make final recommendations regarding applicant's participation in the MHSC network.
- Conduct ongoing monitoring of those Providers approved to be monitored on a "watch status".
- Access clinical peer input when discussing standards of care for a particular type of Provider when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with MHSC's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

Excluded Practitioners

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, MHSC and its Subcontractors may not subcontract with an Excluded Provider/Person. MHSC and its Subcontractors shall terminate Subcontracts immediately when MHSC and its Subcontractors become aware of such excluded Provider/person or when MHSC and its Subcontractors receive notice. MHSC and its Subcontractors certify that neither it nor its member/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 MHSC and its Subcontractors are unable to certify any of the statements in this certification, MHSC and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions

MHSC monitors Provider sanctions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified.

Medicare and Medicaid Sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within thirty (30) calendar days of its release, MHSC reviews the report and if a MHSC network provider is found with a sanction, the Provider's contract is terminated effective the same date the sanction was implemented.

South Carolina Medicaid Excluded Providers List

MHSC screens all Providers against the South Carolina Medicaid Excluded Providers list at the time of initial credentialing and recredentialing. Every thirty (30) days, MHSC also screens all providers against the South Carolina Medicaid Excluded Providers List. If a MHSC network provider is found with a sanction, the practitioner's contract is terminated effective the same date the sanction was implemented.

Sanctions or Limitations on Licensure

MHSC monitors for sanctions or limitations against licensure between credentialing cycles for all network Providers. All sanction or limitation of license information discovered during the ongoing monitoring process will be maintained in the Provider credentialing file. All Providers with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Peer Review & Credentialing Committee meeting for a recommendation.

NPDB Continuous Query

MHSC enrolls all network Providers with the National Practitioner Data Bank ("NPDB") Continuous Query service.
Once the Provider is enrolled in the Continuous Query service, MHSC will receive instant notification of all new NPDB reports against the enrolled Providers. When a new report is received between recredentialing cycles, the Provider will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network.
The complete recredentialing file will be reviewed at the next scheduled Peer Review and Credentialing Committee meeting for a determination.

Member Grievances

MHSC has a process in place to investigate Provider-specific complaints from Members upon their receipt. MHSC evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six months.

Adverse Events

MHSC has a process in place for monitoring Provider adverse events at least every six months. An adverse event is an injury that occurs while a Member is receiving health care services from a Provider. Molina monitors for adverse events at least every six months.

System for Award Management (SAM)

MHSC monitors the SAM once per month to ensure Providers have not been sanctioned. If a MHSC Provider is found with a sanction, the Provider's contract is terminated effective the same date the sanction was implemented.

Medicare Opt-Out

Provider's participating in Medicare must not be listed on the Medicare Opt-Out report. MHSC reviews the Opt Out reports released from the appropriate Medicare financial intermediary showing all of the Providers who have chosen to Opt-Out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other Provider opts out of Medicare, that physician or other Provider may not accept Federal reimbursement for a period of 2 years. These Provider contracts will be immediately terminated for the MHSC Medicare line of business.

Program Integrity (Disclosure of Ownership/Controlling Interest)

During the credentialing and recredentialing process, MHSC requires all Providers to disclose information related to ownership and control, significant business transactions, and persons convicted of crimes. Such information must be disclosed on the SCDHHS Form 1514 to ensure compliance with 42 CFR §455. Providers must report any changes of ownership and disclosure information within thirty-five (35) calendar days of the effective date of the change. At the time of initial credentialing and recredentialing, MHSC screens each of the individuals listed on the SCDHHS Form 1514 against federal and state sanctions and exclusions databases. MHSC also screens these individuals monthly against federal and state sanctions and exclusions databases. MHSC will not contract with an excluded individual or entity. MHSC will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. MHSC will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers. MHSC will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers. The categorical details required and collected at all initial and recredentialing must be current and are as follows:

1. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).
2. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).
3. Detailed identifying information for all individuals or entities that have a 5% or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

The organizational provider, person(s) with ownership or controlled interest in the organizational Provider and managing employees of the organizational Provider must not have ever 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 manufacture, distribution, prescription, or dispensing of controlled substance
- Excluded, expelled or suspended from any federally funded programs, including but not limited to, the Medicare or Medicaid programs
- Excluded, expelled or suspended from any state funded programs, including but not limited to Medicare or Medicaid

Office Site and Medical Record Keeping Practices Review

At the time of initial credentialing, an office site and medical record keeping practice review is conducted at each location in which a Primary Care Practitioner or OB/GYN acting as a Primary Care Provider sees MHSC Members. For multiple-site practices, MHSC reviews every location where Members are seen. The office site review is required prior to the completion of the initial credentialing process. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite the credentialing decision.

A copy of the office site review form(s) will be in the Credentialing file and reviewed at the time a decision is rendered by the MHSC Chief Medical Officer (CMO)/Medical Director or the Peer Review and Credentialing Committee.

New Providers who are joining a contracted medical group that has been reviewed and found to be in compliance with MHSC office site review guidelines will not require another office site review. A copy of the medical group's site and medical record keeping practices review report will be filed in the practitioner's credentials file and reviewed during the initial credentialing process.

If a Primary Care Provider or OB/GYN acting as a Primary Care Provider moves locations or adds additional locations, a new office site review will be conducted within forty-five (45) days of the date MHSC is notified of the change/addition.

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

MHSC assesses one medical/treatment record for orderliness of record and documentation practices. To ensure member confidentiality, MHSC reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Office site and medical record keeping reviews may also be initiated if any Member Grievance are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

Range of Actions, Notification to Authorities and Provider Appeal Rights

MHSC uses established criteria in the review of Provider's performance. All adverse actions taken by the Peer Review and Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

Range of Actions Available

The MHSC Peer Review and Credentialing Committee can take one of the following actions against Providers who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of Patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Chief Medical Officer (CMO)/Medical Director determines the circumstances pose an immediate risk to Patients, a Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case

This applies to all Providers who are contracted by MHSC. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of MHSC Providers

If at any point a Provider fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of Patient care, the Peer Review and Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the Provider may be given the opportunity to appeal this decision.

Criteria for Denial or Termination Decisions by the Peer Review and Credentialing Committee

The criteria used by the Peer Review and Credentialing Committee to make a decision to deny or terminate a Provider from the MHSC network include, but are not limited to, the following:

1. The Provider professional license in any state has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions, including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the Provider acts, omissions or conduct.
3. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Peer Review and Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the Provider to MHSC Members.
4. Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.

5. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the Provider's practice.
6. Provider has or has ever had sanctions of any nature taken by any governmental program or professional body including, but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or Agency.
7. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
8. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
9. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
10. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of MHSC Members.
11. Provider has or has ever engaged in acts which MHSC, in its sole discretion, deems inappropriate.
12. Provider has or has ever had a pattern of member grievances or grievances in which there appears to be a concern regarding the quality of service provided to MHSC Members.
13. Provider has not complied with MHSC's quality assurance program.
14. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
15. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
16. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.
17. Provider has ever rendered services outside the scope of their license.
18. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on Patients.
19. Provider has or has ever failed to comply with the MHSC Medical Record Review Guidelines.
20. Provider has or has ever failed to comply with the MHSC Office Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring on a Committee Watch Status

MHSC uses the credentialing category "watch status" for Providers whose initial or continued participation is approved by the Peer Review and Credentialing Committee with follow-up to occur. The Peer Review and Credentialing Committee may approve a Provider to be monitored on watch status when there are unresolved issues or when the Peer Review and Credentialing Committee determines that the Provider needs to be monitored for any reason.

When a Provider is approved on watch status, the Credentialing Department conducts the follow-up according to the Peer Review and Credentialing Committee direction. Any unusual findings are reported immediately to the MHSC Chief Medical Officer (CMO)/ Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Peer Review and Credentialing Committee meeting for review and recommendation.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, MHSC may work with the Provider to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Within ten (10) calendar days of the Peer Review and Credentialing Committee's decision to place Provider on a corrective action plan, the Provider will be notified via a certified letter from the Chief Medical Officer (CMO)/Medical Director. Such notification will outline:

- The reason for the corrective action
- The corrective action plan

If the corrective actions are resolved, the Provider's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Peer Review and Credentialing Committee may recommend that the Provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate Provider response to corrective action will be brought to the Peer Review and Credentialing Committee for review and decision.

Summary Suspension

In cases where the Peer Review and Credentialing Committee or the Chief Medical Officer (CMO)/Medical Director becomes aware of circumstances that pose an immediate risk to Patients, the Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Chief Medical Officer (CMO)/Medical Director shall promptly notify the Provider of the suspension, via a certified letter. Notification will include the following:

- A description of the action being taken
- Effective date of the action
- The reason(s) for the action and/or information being investigated
- Information (if any) required from the practitioner
- The length of the suspension
- The estimated timeline for determining whether or not to reinstate or terminate the Provider
- Details regarding the Provider's right to request a fair hearing within thirty (30) calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy)
- If the Provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing
- The action will be reported to the NPDB if the suspension is in place longer than thirty (30) calendar days

Upon initiation of the suspension, the Chief Medical Officer (CMO)/Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Peer Review and Credentialing Committee. The Peer Review and Credentialing Committee has the authority to implement corrective action, place conditions on the Provider's continued participation, discontinue the suspension or terminate the Provider.

Initial Credentialing

Denial

After review of appropriate information, the Peer Review and Credentialing Committee may determine that the Provider should not be approved for participation in the MHSC network. The Peer Review and Credentialing Committee may then vote to deny the Provider. Denial of initial credentialing is not reported to the National Practitioner Data Bank (NPDB) and the provider has no Appeal (Fair Hearing) rights when denied at initial credentialing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of denial via certified mail, from the Chief Medical Officer (CMO)/Medical Director, which includes the reason for the denial.

Termination

After review of appropriate information, the Peer Review and Credentialing Committee may determine that the Provider does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Peer Review and Credentialing Committee may then vote to terminate the Provider.

Terminations for Reasons other than Unprofessional Conduct or Quality of Care

If the termination is based on reasons other than unprofessional conduct or quality of care, the Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of termination via certified mail, from the Chief Medical Officer (CMO)/Medical Director, which includes the following:

1. A description of the action being taken
2. Reason for termination

Terminations Based on Unprofessional Conduct or Quality of Care

If the termination is based on unprofessional conduct or quality of care, the Provider will be given the right to a fair hearing. Within ten (10) calendar days of the Committee's decision, the Provider is sent a written notice of MHSC intent to terminate them from the network, via certified mail from the Chief Medical Officer (CMO)/Medical Director, which includes the following:

- A description of the action being taken
- Reason for termination
- Details regarding the Provider's right to request a fair hearing within 30 calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina will appoint a hearing officer and a panel of individuals to review the Appeal
- The Provider does not request a fair hearing within the thirty (30) calendar days; they have waived their rights to a hearing.
- The notice will include a copy of the Fair Hearing Plan Policy describing the process in detail
- Provider's right to be represented by an attorney or another person of their choice
- Obligations of the Provider regarding further care of Molina Patients/Members
- The action will be reported to the NPDB and the State Licensing Board

MHSC will wait thirty (30) calendar days from the date the terminated Provider received the notice of termination. If the Provider requests a fair hearing within that required timeframe, MHSC will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the Provider will receive written notification of the appeal decision which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee's decision is to uphold the termination, the action will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the Provider remains in the MHSC network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the Provider does not request a hearing within the thirty (30) calendar days, they have waived their rights to a hearing and

the termination will become the final decision. A written notification of the final termination will be sent to the Provider and the termination will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below.

Reporting to Appropriate Authorities

MHSC will make reports to appropriate authorities as specified in the Fair Hearing Plan Policy when the Peer Review and Credentialing Committee takes or recommends certain adverse actions for a Provider based upon unprofessional conduct or quality of care. Adverse actions include:

- Revocation, termination of, or expulsion from MHSC Provider status
- Summary Suspension in effect or imposed for more than thirty (30) calendar days
- Any other final action by MHSC that by its nature is reportable to the State Licensing Board and the NPDB

Within fifteen (15) calendar days of the effective date of the final action, the manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the Provider it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the Provider's credentials file. The action is also reported to other applicable State entities as required.

The following actions will be reported to South Carolina Department of Health and Human Services (SCDHHS):

- Any excluded individuals and entities discovered during the credentialing or recredentialing processes
- Any actions taken to terminate a relationship with excluded individuals or entities
- Any payments made to an excluded individual or entity and the recovery of such payments
- Any individuals or entities discovered during the credentialing, recredentialing, or monthly monitoring process with an ownership or control interest
- All Providers approved on a watch status
- Any Provider who has been denied, terminated or suspended from the network

Fair Hearing Plan Policy

Under State and Federal law, certain procedural rights shall be granted to a provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board, the National Practitioner Data Bank ("NPDB"),

Molina Healthcare, Inc., and its affiliates Molina Healthcare of South Carolina ("MHSC"), will maintain and communicate the process providing procedural rights to providers when a final action by MHSC will result in a report to the State Licensing Board and NPDB.

A. Definitions

1. Adverse Action shall mean an action that entitles a provider to a hearing, as set forth in Section B (l)-(3) below.
2. Chief Medical Officer (CMO)/Medical Director shall mean the Chief Medical Officer (CMO)/Medical Director for MHSC.
3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.

4. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.

5. Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).

6. State shall mean the licensing board in the state in which the provider practices. In South Carolina this would be the South Carolina Department of Labor, Licensing and Regulation.

7. State Licensing Board shall mean the state agency responsible for the licensure of provider. In South Carolina this would be the South Carolina Department of Labor, Licensing and Regulation.

8. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a provider violates a material term of the provider's contract with Molina Healthcare of South Carolina.

B. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review and Credentialing Committee takes or recommends any of the following Adverse Actions for a provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from MHSC Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board and NPDB.

2. Suspension, reduction, limitation, or revocation of authority to provide care to MHSC members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board and NPDB.

3. Any other final action by MHSC that by its nature is reportable to the State Licensing Board and NPDB.

C. Notice of Action

If the Peer Review and Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;

2. State any Credentialing Policy provisions that have been violated;

3. Advise the provider that he/she has the right to request a hearing on the proposed Adverse Action;

4. Advise the provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Fair Plan Chief Medical Officer (CMO)/Medical Director by certified mail, return receipt requested, or personal delivery;

5. Advise the provider that he/she has the right to be represented by an attorney or another person of their choice.

6. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law; and

7. Provide a summary of the provider's hearing rights or attach a copy of this Policy.

D. Request for a Hearing - Waiver

If the provider does not request a hearing in writing to the Chief Medical Officer (CMO)/Medical Director within thirty (30) days following receipt of the Notice of Action, the provider shall be deemed to have accepted the action or recommendation of the Peer Review and Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer (CMO)/Medical Director for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review and Credentialing Committee shall provide the provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review and Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the

Chief Medical Officer (CMO)/Medical Director for final approval. In the event of a submittal to the Chief Medical Officer (CMO)/Medical Director upon the provider's waiver as set forth herein, the Peer Review and Credentialing Committee may submit to the Chief Medical Officer (CMO)/Medical Director additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer (CMO)/Medical Director in accepting or rejecting the recommended Adverse Action.

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

The Chief Medical Officer (CMO)/Medical Director shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of three or more providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected provider. In the event providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Chief Medical Officer (CMO)/ Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:

a. Evaluate evidence and testimony presented.

b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review and Credentialing Committee.

c. Maintain the privacy of the hearing unless the law provides to the contrary.

4. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer (CMO)/Medical Director any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

F. Hearing Officer

1. Selection

The Chief Medical Officer (CMO)/Medical Director shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

a. Exclude any witness, other than a party or other essential person.

b. Determine the attendance of any person other than the parties and their counsel and representatives.

c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:

a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;

b. Ensure that proper decorum is maintained;

c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;

d. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;

e. Issue rulings on any objections or evidentiary matters;

f. Discretion to limit the amount of time;

g. Assure that each witness is sworn in by the court reporter;

h. May ask questions of the witnesses (but must remain neutral/impartial);

i. May meet in private with the panel members to discuss the conduct of the hearing;

j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;

k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and

l. Prepare the written report.

G. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer (CMO)/Medical Director shall schedule and arrange for a hearing. The Chief Medical Officer (CMO)/Medical Director shall give notice to the affected provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings. The South Carolina DHHS Medical Director will also be notified of the hearing and will be allowed to attend if he/she requests to do so.

H. Notice of Hearing

The Notice of Hearing shall contain and provide the affected provider with the following:

1. The date, time and location of the hearing.

2. The name of the Hearing Officer.

3. The names of the Hearing Committee Members.

4. A concise statement of the affected provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.

5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review and Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.

6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the

provider to prepare a defense, including all documentary evidence which was considered by the Peer Review and Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

I. Pre-Hearing Procedures

1. The provider shall have the following pre-hearing rights:

   a. To inspect and copy, at the provider's expense, documents upon which the charges are based which the Peer Review and Credentialing Committee have in its possession or under its control; and

   b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the provider to prepare a defense, including all evidence that was considered by the Peer Review and Credentialing Committee in recommending Adverse Action.

2. The Hearing Committee shall have the following pre-hearing right:

   To inspect and copy, at MHSC's expense, any documents or other evidence relevant to the charges which the provider has in his or her possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:

   a. Whether the information sought may be introduced to support or defend the charges;

   b. The exculpatory or inculpatory nature of the information sought, if any;

   c. The burden attendant upon the party in possession of the information sought if access is granted; and

   d. Any previous requests for access to information submitted or resisted by the parties.

4. The provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

5. It shall be the duty of the provider, the Peer Review and Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.

7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

J. Conduct of Hearing

1. Rights of the Parties

   Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

   a. Call and examine witnesses for relevant testimony.

   b. Introduce relevant exhibits or other documents.

c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.

d. Otherwise rebut evidence.

e. Have a record made of the proceedings.

f. Submit a written statement at the close of the hearing.

g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The provider may be called by the Peer Review and Credentialing Committee and examined as if under cross-examination.

2. Course of the Hearing

a. Each party may make an oral opening statement.

b. The Peer Review and Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.

c. The affected provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.

d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.

e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

3. Use of Exhibits

a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.

b. A description of the exhibits in the order received shall be made a part of the record.

4. Witnesses

a. Witnesses for each party shall submit to questions or other examination.

b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.

c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.

d. The party producing such witnesses shall pay the expenses of their witnesses.

5. Rules for Hearing

a. Attendance at Hearings

Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee

There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written

communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter

Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
    a. The panel members' names and specialties;
    b. The Hearing officer's name;
    c. The date of the hearing;
    d. The charges at issue; and
    e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review and Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review and Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review and Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by M, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or

respond to appropriate questions.

P. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Chief Medical Officer (CMO)/Medical Director, the Peer Review and Credentialing Committee imposing the Adverse Action, and the affected provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer (CMO)/Medical Director shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer (CMO)/Medical Director's action constitutes the final decision.

S. Reporting

In the event the Chief Medical Officer (CMO)/Medical Director adopts the proposed decision of the Peer Review and Credentialing Committee taking or recommending the Adverse Action, MHSC will submit a report to the State Licensing Board and NPDB as required. Reports shall be made in accordance with the Credentialing Program Policy.

Reports to the State Licensing Board and NPDB for adverse actions must be submitted within fifteen (15) days from the date the adverse action was taken.

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the provider must exhaust the remedies afforded by this Policy before resorting to legal action.

U. Confidentiality and Immunity

Information regarding any practitioner or provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a "Representative" shall mean any individual authorized to perform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section "information" may be any written or oral disclosures including, but not limited to, a practitioner's or provider's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or practitioner's or provider's provision of patient care services.

By providing patient care services at MHSC, a practitioner or provider:

1. Authorizes representatives of MHSC to solicit, provide, and act upon information bearing on the practitioner's or provider's qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, MHSC membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal law. To the fullest extent permitted by State or Federal law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider or Practitioner;
2. Actions reducing, suspending, terminating or revoking a practitioner's and provider's status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any MHSC operations and actions relating to practitioner and provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a practitioner or provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a practitioner or provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the practitioner or provider, or if permitted or required by law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant state and federal law, and are not a limitation thereof.

Section 11. Appeals and Grievance Process

MHSC members or member's personal representatives have the right to file a Grievance and submit an Appeal through a formal process. All Grievances and Appeals must first be submitted to MHSC for resolution. Members also have access to the State Fair Hearing system if they are dissatisfied with MHSC's final determination of an Appeal.

MHSC members and Providers will not be penalized, discriminated against or otherwise retaliated against for filing a Grievance or Appeal. Members are informed of their Grievance and Appeal rights and their access to the State Fair Hearing system (for Appeals) through various general communications including, but not limited to, the member handbook, and Disclosure, Member Newsletters and Molina Healthcare's website: www.MolinaHealthcare.com.

This section addresses the identification, review and resolution of Member Grievances and Appeals. Below are MHSC's Member Grievance and Appeals Process.

Definitions

Action: Action means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, or act within the timeframes set forth by the State.

Appeal: An Appeal is a request for MHSC to review an action/decision made.

Clinical Peer: Clinical peer means a healthcare professional who is in the same profession and the same or similar specialty as the healthcare Provider who typically manages the medical condition, procedures, or treatment under review.

Expedited Appeal: An Expedited Appeal is a request for MHSC to review an action where the action is related to a hospital admission, continued stay, or other healthcare services, when following the standard Appeals timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

Grievance: Grievance means any expression of dissatisfaction about a matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of personal relationships such as rudeness or a Provider or employee or failure to respect a member's rights.

Grievance and Appeals Committee: Grievance and Appeals Committee means individuals who have been appointed by MHSC to monitor and review the quarterly reports regarding grievances and Appeals.

Second Opinion

If a member or member's authorized representative does not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members can call Member Services to find out how to get a second opinion, and under what circumstances a second option can be obtained/approved.

Providers may also request a second opinion for a member if certain clinical requirements are met. Providers should call Provider Services for additional information regarding MHSC's Second Opinion Policy.

Member Grievance Process:

If a member is unhappy with the service from MHSC or Providers contracted with MHSC, they may file a Grievance by contacting Member Services toll-free at (855) 882-3901. They can also write to us at:

Molina Healthcare of South Carolina
Attn: MIRR Dept.
4105 Faber Place Dr. Ste. 120
Charleston, SC 29405
Or via fax: (877) 823-5961

All grievances, whether oral or written, are documented and logged in all appropriate systems. Members may identify an individual,

including an attorney or Provider, to serve as a personal representative to act on their behalf at any stage during the Grievance and Appeals process. If under applicable law, a person has authority to act on behalf of a member in making decision related to health care or is a legal representative of the member, MHSC will treat such person as a personal representative. The member (or authorized representative) shall have the right to participate in the formal grievance proceedings.

When needed, members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for members with limited English proficiency or other limitations, e.g., hearing impaired, requiring communication support.

MHSC does not discriminate against, retaliate against, or take any other form of punitive action against members or members' representatives for utilizing the grievance process. MHSC does not take punitive action of any kind against Providers for assisting members in the grievance process.

Any grievance regarding a potential quality of care or service issue is referred to the Quality Improvement Department for further investigation. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Compliance Department.

MHSC has an organized grievance process to ensure thorough, appropriate and timely resolution to member's grievances. Grievance analysis is performed regularly to identify trends, concerns and opportunities for improvement.

Grievance Timelines

Grievances may be filed orally or in writing within ninety (90) calendar days from the date the member became aware of an issue. Oral grievances are acknowledged at the time of filing and written acknowledgement is issued within five (5) business days for grievances filed in writing.

All grievances are resolved within ninety (90) calendar days.

The time frame to resolve a grievance may be extended another fourteen (14 days) if the member/authorized representative or MHSC think it would be in the member's best interest (for example, additional information is needed). If an extension is requested, MHSC must document to the satisfaction of the SCDHHS that there is need for more time to receive additional information and explain how the delay is in the member's best interest. If approved, a letter will be sent to the member informing them of the extension and why it was requested.

Appeals

An Appeal is a request for MHSC to review an action/decision made regarding a request for services including the type, level, and duration of services. Appeals may be submitted by members, Providers or their authorized representative acting on behalf of the member with written consent. When a requested healthcare service has been denied in whole or part, the members are sent a notice of the denied action. The following is included in the notice:

- Their right to Appeal the decision
- The process by which the Appeal is initiated
- The MHSC Customer Service phone number where more information regarding the Appeal process can be obtained
- The availability of MHSC to assist the member in filing an Appeal if needed

All Appeals that involve a denial based on clinical medical necessity will be reviewed by the Chief Medical Officer (CMO)/Medical Director who was not involved in any previous level of review or decision-making and has the appropriate clinical expertise. When appropriate, Appeals will be sent out for an independent review to ensure it meets the NCQA guidelines of a clinical review by a "same or similar" specialty. A written Appeal resolution letter will contain reasons for the determination including the medical or clinical criteria for the determination. The letter will also provide the member with their State Fair Hearing rights.

Members who are not satisfied with MHSC's Appeal determination may request a State Fair Hearing. A State Fair Hearing must be requested within thirty (30) calendar days from the date of receipt of the Appeal resolution notice.

Standard Appeals Process and Timeline

Standard Appeals may be submitted orally or in writing. Oral Appeals must be followed by a written Appeal request. Standard Appeals must be filed within ninety (90) calendar days from the date of the notice of action and may be submitted to:

Molina Healthcare of South Carolina
Attn: MIRR Dept.
4105 Faber Place Dr. Ste. 120
Charleston, SC 29405
Or
Via Fax: (877) 823-5961
Or
Via Phone: (855) 882-3901

MHSC will acknowledge receipt and notify the party filing the Appeal of all information that is required to evaluate the Appeal. MHSC will render a decision on the Appeal within thirty (30) calendar days from the date of receipt of the Appeal. The time frame to resolve an Appeal may be extended another fourteen (14) days if the member/authorized representative or MHSC think it would be in the member's best interest (for example, additional information is needed).

Expedited Appeals Process and Timeline

Expedited Appeals are available when following the standard Appeals time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited Appeals may be submitted orally or in writing. Expedited Appeals can be filed within ninety (90) calendar days from the date of notice of action. If submitted orally, a written Appeal request is not needed. Submit requests to:

Molina Healthcare of South Carolina
Attn: MIRR Dept.
4105 Faber Place Dr. Ste. 120
Charleston, SC 29405
Or
Via Fax: (877) 823-5961
Or
Via Phone: (855) 882-3901

Upon receipt of an expedited Appeal request, MHSC will notify the party filing the Appeal as soon as possible, and within no more than twenty-four (24) hours after receipt, of all information that is required to evaluate the Appeal. If the request to expedite is approved, MHSC will render a decision within seventy-two (72) hours of receipt of the Appeal request, unless an extension is granted as mentioned above. If the request to process the Appeal as expedited is denied, MHSC will notify the member or authorized representative promptly via telephone of the result of the resolution process and the date it was completed. Within two (2) calendar days of the decision, MHSC will provide written notification of the decision to deny the processing of the Appeal as expedited and inform the member that they can grieve the decision. The Appeal will then be processed as a standard Appeal.

MHSC will attempt to provide oral notification to the member/member's representative of the Appeal determination promptly after determination is made. Oral notification will be followed up by a written notice of determination. Where a service denial is reversed, the Provider will be notified of the determination as promptly as possible. In all Appeals, members can present evidence and examine the case file and other documents related to the Appeal.

State Fair Hearing

The State Fair Hearing system is available to members after they have exhausted MHSC's internal Appeal process and are dissatisfied with the determination. Requests for a State Fair Hearing must be made no later than thirty (30) calendar days from the date of receipt of MHSC's determination notice.

MHSC will participate in the State Fair Hearing process by completing all required documents within the required time frame and providing to Appeal information, including, but not limited to, medical records, claim payment records.

Continuation of Benefits

A member has the right to continue receiving services during the Appeal process if requested in writing within ten (10) calendar days from the date on the denial notice. If the final resolution of the Appeal decision is made and it is not in the member's favor, they may be responsible for the cost of the care received during the Appeal process.

Provider Claim Dispute/Claim Re-determination Request

Providers seeking a redetermination of a claim previously adjudicated must request such action within ninety (90) calendar days of MHSC's original remittance advice date. Additionally, the item(s) being resubmitted should be clearly marked as a redetermination and must include the following documentation:

- The item(s) being resubmitted should be clearly marked as a Claim Dispute/ Adjustment
- Payment adjustment requests must be fully explained
- The previous claim and remittance advice, any other documentation to support the adjustment and a copy of the Referral/ Authorization form (if applicable) must accompany the adjustment request
- The claim number clearly marked on all supporting documents

These requests shall be classified as a Claims Disputes/Adjustment and be sent to the following:

Molina Healthcare of South Carolina
Attention: Claims Disputes / Adjustments
4105 Faber Place Dr. Ste. 120
Charleston, SC 29405

OR

Via Fax: (877) 901- 8182

The Provider will be notified of MHSC's decision in writing within thirty (30) business days of receipt of the Claims Dispute/ Adjustment request. Providers may request a claim dispute/adjustment when the claim was incorrectly denied as a duplicate or due to claims examiner or data-entry error.

Section 12. HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

MHSC's Commitment to Patient Privacy

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

Provider/Practitioner Responsibilities

MHSC expects that its contracted Providers/practitioners will respect the privacy of MHSC members and comply with all applicable laws and regulations regarding the privacy of Patient and member PHI.

Applicable Laws

Providers/practitioners must understand all state and federal healthcare privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of laws that Providers/practitioners must comply with. In general, most healthcare Providers/practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

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

Providers/practitioners should be aware that HIPAA provides a floor for Patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/practitioners should consult with their own legal counsel to address their specific situation.

Uses and Disclosures of PHI

Member and Patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/practitioner may use and disclose PHI for their own treatment, payment, and healthcare operations activities (TPO) without the consent or authorization of the Patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider/practitioner's own TPO activities, but also for the TPO of another covered entity[2]. Disclosure of PHI by one covered entity to another covered entity, or healthcare Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a healthcare Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[3]."

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

---

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

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

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

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

Written Authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the Patient. Authorizations should meet the requirements of HIPAA and applicable state law. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient's Rights

Patients are afforded various rights under HIPAA. MHSC Providers/practitioners must allow Patients to exercise any of the below-listed rights that apply to the Provider/practitioner's practice:

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

HIPAA Security

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

In addition, medical identity theft is an emerging threat in the healthcare industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such as health insurance information – without the person's knowledge or consent to obtain healthcare services or goods. Medical identity theft frequently results in erroneous entries being put

into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to MHSC.

HIPAA Transactions and Code Sets

MHSC strongly supports the use of electronic transactions to streamline healthcare administrative activities. MHSC Providers/practitioners are encouraged to submit claims and other transactions to MHSC using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

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

MHSC is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/practitioners who wish to conduct HIPAA standard transactions with MHSC should refer to Molina Healthcare's website at http://www.MolinaHealthcare.com for additional information. Click on the tab titled "Providers," select a state, click the tab titled "HIPAA" and then click on the tab titled "TCS readiness."

National Provider Identifier

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

Additional Requirements for Delegated Providers/Practitioners

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

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:_____ Member ID #:_____

Member Address:_____ Date of Birth:_____

City/State/Zip:_____ Telephone #:_____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

_____

_____

_____

2. Name of persons/organizations authorized to receive the protected health information:

_____

_____

_____

3. Specific description of protected health information that may be used/disclosed:

_____

_____

_____

4. The protected health information will be used/disclosed for the following purpose(s):

_____

_____

_____

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so: Yes_____ No_____

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare of South Carolina may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare of South Carolina reserves the right to deny that health care.
9. I understand that I have a right to receive a copy of this authorization, if requested by me.
10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare of South Carolina in writing, except to the extent that:
    a) action has been taken in reliance on this authorization; or
    b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.
11. I understand that the information I authorize a person or entity to receive may be no longer be protected by federal law and regulations.
12. This authorization expires on the following date or event* : _____
    *If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below.

Signature of Member or Member's Personal Representative	Date
Printed Name of Member or Member's Personal Representative, if applicable	Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina Healthcare of South Carolina.

Section 14. Glossary of Terms

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

Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute InPatient Care – Care provided to persons sufficiently ill or disabled requiring:

I Constant availability of medical supervision by attending Provider or other medical staff
II Constant availability of licensed nursing personnel
III Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the Provider

Ambulatory Care – Health services provided on an outPatient basis. While many inPatients may be ambulatory, the term ambulatory care usually implies that the Patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows Patients to leave the facility the same day surgery or delivery occurs.
Ancillary Services – Health services ordered by a Provider, including but not limited to, laboratory services, radiology services, and physical therapy.

Appeal – A written request by a member or member's personal representative received at MHSC for review of an action.
Authorization – Approval obtained by Providers from MHSC for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total Patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care services.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

CFR – Code of Federal Regulations.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that Provider status be extended only to professional, competent Providers who continually meet the qualifications, standards, and requirements established by MHSC.
Current Procedural Terminology (CPT) Codes – American Medical Association (AMA) approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which healthcare is delivered to a Patient. Examples include, but are not limited to, hospitals,

Providers' offices and home health care.

Denied Claims Review – The process for Providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It is also equipment that is appropriate for use in the home and prescribed by a Provider.

Dual Eligible – Applicants that receive Medicaid and Medicare benefits.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Emergency Care – The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Encounter Data – MHSC shall collect, and submit to DHHS, enrollee service level encounter data for all covered services.

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

Expedited Appeal – An oral or written request by a member or member's personal representative received by MHSC requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.

Expedited Grievance – A grievance where delay in resolution would jeopardize the member's life or materially jeopardize the member's health.

Federally Qualified Health Center (FQHC) – A South Carolina licensed health center that is certified by CMS that received Public Health Services grants. A FQHC provides a wide range of primary care and enhanced services in a medically under-served area. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee for service program.

Fee-For-Service (FFS) – FFS is a term MHSC uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member.

Fraud – 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).

Grievance – An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an Action received at MHSC.

Health Plan Effectiveness Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, Provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPAA – Health Insurance Portability and Accountability Act.

Independent Practice Association (IPA) – A legal entity, the members of which are independent Providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.

Medically Necessary – A service, supply or medicine is appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, the prevention of future disease, to assist in the enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth, as determined by the Provider in accordance with MHSC's guidelines, policies and/or procedures.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

- Part A covers the Medicare inPatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care
- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare Provider's services, outPatient hospital care, outPatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare

Member – A current or previous member of MHSC.

NCQA – National Committee for Quality Assurance.

Participating Provider – A Provider that has a written agreement with MHSC to provide services to members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of Providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a Provider or Provider group that may directly or indirectly have the effect of reducing or limiting services to members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating Provider responsible for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to: Pediatricians, Family Practice Providers, General Medicine Providers, Internists, Obstetrician/Gynecologists, Physician Assistants (under the supervision of a Physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by MHSC.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a Patient to another Provider for services or consultation which the referring Provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – A state licensed rural health clinic that is certified by CMS and receives Public Health Service grants. Service Area – A geographic area serviced by MHSC, designated and approved by the South Carolina Department of Health and

Human Services (SCDHHS).

Specialist – Any licensed Provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA. Sub-Contract – A written agreement between a health plan and a participating Provider, or between a participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than MHSC liable for payment of health care services rendered to members. MHSC will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for SCHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or Patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Waste – Healthcare spending that can be eliminated without reducing the quality of care. Quality Waste includes, overuse, underuse, and ineffective use. Inefficiency Waste includes redundancy, delays, and unnecessary process complexity. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid/Medicare programs.

Appendix

MHSC Forms and Materials

The following MHSC forms and reference materials have been included for your use. Please feel free to make copies as needed.

- Pregnancy Notification Report
- SBIRT Integrated Screening Tool
- 2015 SC PA Pre-Service Guide
- Case Management Referral Form (7/14/15 - needs State Approval per Laura S./Carla)
- Transportation Brokers Grid

MOLINA HEALTHCARE Healthy Connections

Your Extended Family.

Molina Healthcare of **South Carolina**

Prior Authorization/Pre-Service Review Guide • Effective: 08/01/2015

Use the Molina web portal for faster authorization turnaround times
Contact Provider Services for details
*****Referrals and Office Visits to Participating Molina Network Specialists do not require Prior Authorization*****

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Members
Refer to Molina's website for specific codes that require authorization
Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, Partial hospitalization, Day Treatment
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting)**
- **Durable Medical Equipment:** Refer to Molina's website or portal for specific codes that require authorization.
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations
- **Habilitative Therapy** – After initial evaluation plus six (6) visits for outpatient and home settings (per state benefit)
- **Home Healthcare and Home Infusion:** After initial evaluation plus six (6) visits
- **Hospice & Palliative Care:** notification only
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty Imaging:** Refer to Molina's website or portal for specific codes that require authorization
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only)
- **Long Term Services and Supports (LTSS):** For Healthy Connections Prime program only. Most LTSS services require authorization.
- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay
  - Local Health Department (LHD) services
  - Other services based on state requirements
- **Office Visits and Procedures at Participating Providers do not require authorization**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's website or portal for specific codes that require authorization
- **Pain Management Procedures:** except trigger point injections
- **Pregnancy and Delivery:** notification only
- **Prosthetics/Orthotics:** Refer to Molina's website or portal for specific codes that require authorization
- **Radiation Therapy and Radiosurgery (for selected services only):** Refer to Molina's website for specific codes that require authorization
- **Sleep Studies**
- **Specialty Pharmacy drugs (oral and injectable):** Refer to Molina's website for a list of the specific codes requiring authorization
- **Speech Therapy:** After initial evaluation
- **Transplants including Solid Organ and Bone Marrow**
  Kidney transplants require authorization through the SC-DHHS contracted QIO (Quality Improvement Organization) KeyPro. Fax such requests to (855) 300-0082
  Solid organ and bone marrow transplants – fax requests to Molina (855) 237-6178
  Corneal transplants do not require authorization
- **Transportation:** non-emergent ambulance (ground and air)
- **Unlisted and Miscellaneous Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request. Refer to Molina's website or portal for specific codes that require authorization

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)**

Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, and evidence of medical necessity during the claim review.

3470523SC1115

MOLINA HEALTHCARE Healthy Connections

Your Extended Family.

Molina Healthcare **Prior Authorization Request Form**

Phone Number: (855) 237-6178 • Fax Number: (866) 423-3889

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider 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, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (855) 237-6178

Important Molina Healthcare Medicaid Information	
Prior Authorizations: 8:00 a.m. – 5:00 p.m. Phone: (855) 237-6178 Fax: (866) 423-3889 **Radiology Authorizations:** Phone: (855) 714-2415, press 8 Fax: (877) 731-7218 **NICU Authorizations:** Phone: (888) 562-5442 ext. 117453 or 114768 Fax: (877) 731- 7218 **PHARMACY Authorizations:** **Healthy Connections Medicaid** Phone: (855) 237-6178, option 2 Fax: (855) 571-3011 **Healthy Connections Prime (Molina Dual Options)** Phone: (855) 735-5831 Fax: (866) 290-1309 **Behavioral Health Authorizations:** Phone: (855) 237-6178 Fax: (866) 423-3889 **Transplant Authorizations:** Phone: (855) 237-6178 Fax: (866) 423-3889	**Provider Customer Service**: 8:00 a.m. – 5:00 p.m. Phone: (855) 237-6178 TTY/TDD: 711 **Member Customer Service Benefits/Eligibility:** Healthy Connections Medicaid Hours: 8:00 a.m. – 6:00 p.m. Phone: (855) 882-3901 TTY/TDD: 711 Healthy Connections Prime (Molina Dual Options) Hours: 8:00 a.m. – 8:00 p.m. Phone: (855) 735-5831 TTY/TDD: 711 **24 Hour Nurse Advice Line** English: 1 (888) 275-8750 [TTY: 711] Spanish: 1 (866) 648-3537 [TTY: 711] **Vision Care: March Vision** Phone: (888) 493-4070 **Dental: DentaQuest** Phone: (888) 307-6552 Transportation: Logisticare Provides This Service -For assistance in getting help with transportation please call Molina's Member Services at (855) 882-3901

Providers may utilize Molina Healthcare's eWeb at: www.molinahealthcare.com

- **Available features include:**
- **Authorization submission and status**
- **Member Eligibility**
- **Claims submission and status**
- **Provider Directory**
- **Download frequently used forms**
- **Nurse Advice Line Report**

MOLINA HEALTHCARE
Your Extended Family.

Healthy Connections

Molina Healthcare **Prior Authorization Request Form**

Phone Number: (855) 237-6178 • Fax Number: (866) 423-3889

MEMBER INFORMATION			
Plan:	☐ **Healthy Connections Medicaid** ☐ **Healthy Connections Prime (Molina Dual Options)**		
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*	

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

REFERRAL/SERVICE TYPE REQUESTED			
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Pre-Procedure Testing ☐ Speech Therapy ☐ Other:	☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Habilitative Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office**

ICD-10 Diagnosis Codes and Descriptions:			
CPT/HCPC Code & Description:			
Number of visits requested:		Date(s) of Service:	
Number of visits or units used since 7/1 of the previous year (as applicable)	☐ Visits: ☐ Units:	_____Speech _____ Habilitative Therapy	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Provider or Facility Providing Service:			
Contact at Requesting Provider's office:			
Rendering Provider National Provider ID# (NPI): if known			
Phone Number:	( )	Fax Number:	( )

For Molina Use Only:

Providers may obtain a copy of this form on the Molina website: http://www.molinahealthcare.com/providers/sc/medicaid/Pages/home.aspx

or on the Molina Forms web page: http://www.molinahealthcare.com/providers/sc/medicaid/forms/Pages/fuf.aspx

MOLINA HEALTHCARE

Healthy Connections

Pregnancy Notification Report

Thank you in advance for completing this form

Please complete all sections and fax within **7 days** of the **first** prenatal visit and/or positive pregnancy test.

Today's Date: ____/____/____

DIRECTIONS FOR COMPLETION OF FORM:

Step 1: Complete all member information.

Step 2: Complete the OB/GYN section with the name of the OB/GYN to whom the member was referred for prenatal care.

Step 3: Fax form to Molina Healthcare at **1 (866) 423-3889**

Step 4: If you have any questions or need some assistance, please contact us at **1 (855) 237-6178**

STEP 1: MEMBER INFORMATION

Member's Name:	Member ID/CIN:
Address:	City: State: ZIP:
Member DOB: / /	Phone #: ( ) - Alternate Ph.#: ( ) -
Date of Positive Pregnancy Test: / /	Preferred Language:
LMP:	EDC:
Gravida: Para:	Number of Live Births:

High Risk Condition(s) (if known):

CURRENT PREGNANCY

- ☐ Hypertension
- ☐ Excessive Nausea & Vomiting
- ☐ Diabetes
- ☐ Pre-term labor
- ☐ Smoking
- ☐ Multiple Gestation
- ☐ No problems with Current Pregnancy
- Other:_____

PAST PREGNANCY ☐ N/A

- ☐ Hypertension
- ☐ Diabetes
- ☐ Pre-term labor
- ☐ Pre-term delivery
- ☐ No problems with Past Pregnancy
- ☐ Other:_____

STEP 2: OB/GYN INFORMATION

OB/GYN Practitioner's Name:
OB/GYN Practitioner's Phone Number: ( ) -
Date of First Prenatal Appointment: / /
Referring Practitioner: Phone: ( ) -

STEP 3: FAX FORM TO MOLINA HEALTHCARE

Fax to Molina Healthcare Fax line at **1 (866) 423-3889**

STEP 4: CALL MOLINA WITH QUESTIONS

If you have any questions or need assistance, please contact us at **1 (855) 237-6178**

Thank you for taking such good care of our members!

[Original form to remain in member's chart]

Pregnancy Notification Form_SC version2_12 1 14

MOLINA HEALTHCARE

Healthy Connections

Case Management Referral Form

The Molina Case Management program is designed to assist you and our members to achieve optimal health care outcomes. Molina Case Management provides a comprehensive program with Transition of Care Coach-RNs, Case Managers, and Community Connectors. The team is available to provide in-home or hospital visitation and to assist members with how to navigate the care system and obtain necessary services that will adequately meet their medical needs. Molina members may be referred to Case Management if they are actively in treatment but are failing to meet care plan milestones, however all members are eligible for our Case Management program. If you would like to refer a Molina Healthcare member for this program, please fax completed form to: **Molina Healthcare of South Carolina, Case Management Department at 1.855.860.7197.**

Date: _____

Referral Requestor:	Requestor Contact #:
Member Name:	Member ID#:
Member Phone #:	Primary Language
Legal Guardian Name:	PCP (name or #):

Please complete all that apply.

Reason for Referral:

☐ High Risk Obstetrics-Gestational Age (less than 35 Weeks		
☐ Catastrophic Condition (Adult and Pediatric)		
☐ Catastrophic/complex diagnosis requiring coordination of care, connection to services, coordination of benefits		
☐ Compounding psyschosocial factors presenting actual or potential barriers to care		
☐ Chronic condition requiring:		
☐ Three or more hospitalizations with the past 6 months		☐ Non-healing wound requiring active treatment for a duration greater than 3 months
HIV/AIDS:	☐ HIV	☐ AIDS
End Stage Renal Disease:	☐ Hemodialysis	☐ Peritoneal dialysis
Transplant Type:		
Continuity of Care Services (explain): Does the member have a need for continued services?		
Current Services Needed:		
List any Behavioral Care Needs:		
Caregiver Available to Assist (name/#):		

Comments:

If you would like to speak directly to a Case Management team member, please call 843.740.1779

Transportation Broker Listing and Contact Information

Broker: LogistiCare	Broker: LogistiCare	Broker: LogistiCare
If you live in one of these counties call: 1-866-910-7688 **Region 1** Abbeville Anderson Cherokee Edgefield Greenville Greenwood Laurens McCormick Oconee Pickens Saluda Spartanburg	If you live in one of these counties call: 1-866-445-6860 **Region 2** Aiken Allendale Bamberg Barnwell Calhoun Chester Clarendon Fairfield Kershaw Lancaster Lee Lexington Newberry Orangeburg Richland Sumter Union York	If you live in one of these counties call: 1-866-445-9954 **Region 3** Beaufort Berkeley Charleston Chesterfield Colleton Darlington Dillon Dorchester Florence Georgetown Hampton Horry Jasper Marion Marlboro Williamsburg