MOLINA® HEALTHCARE

Your Extended Family.

Provider Manual

Molina Healthcare of Florida

8300 NW 33rd Street, Suite 400
Doral, FL 33122
Phone: (866) 472-4585
Fax: (866) 422-6445

Dear Provider:

I would like to extend a personal welcome to Molina Healthcare of Florida, Inc. Enclosed is your Molina Healthcare Provider Manual, written specifically to address the requirements of delivering health care services to Molina 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 Molina Healthcare contract. The sample forms are included to illustrate what is needed for appropriate documentation.

From time to time we will need to update and revise this manual as our policies or regulatory requirements change. All changes will be sent to you as additions to or deletions from this manual. You simply need to replace old pages with the new ones.

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,

David Pollack
President
Molina Healthcare of Florida, Inc.

Molina Healthcare of Florida, Inc. - Provider Manual

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Section 1. Addresses and Phone Numbers

Member Services Department

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

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

Claims Department

The Claims Department is located at our corporate office in Long Beach, CA. All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use Emdeon EDI Claims/ Payor ID number - **51062**. To verify the status of your claims, please call our Provider Claims Representatives at the numbers listed below.

Claims	
Address	Molina Healthcare of Florida PO BOX 22812 Long Beach, CA 90801
Phone:	(866) 472-4585

Claims Recovery Department

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

Claims Recovery	
Address	Molina Healthcare of Florida PO BOX 22812 Long Beach, CA 90801
Phone:	(866) 472-4585

Credentialing Department

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

Credentialing	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(866) 472-4585
Fax:	(866) 422-6445

Health Line (24-Hour Nurse Advice Line)

This telephone-based nurse advice line is available to all Molina Healthcare Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

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

Healthcare Services Department

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

Healthcare Services Authorizations & Inpatient Census	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(866) 472-4585
Fax:	(866) 440-4791 (Medicaid) (866) 472-9509 (Florida Medicare)

Health Education & Health Management Department

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

Health Education & Management	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(866) 472-4585
Fax:	(866) 422-6445

Behavioral Health

Psychcare manages all components of behavioral health for Molina Healthcare Members.

PsychCare	
Address:	Psychcare Attn: Claims Department 10200 Sunset Drive Miami, FL 33173
Phone:	(800) 221-5487
(24) Hours per day, (365) day per year	

Pharmacy Department

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

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

Provider Services Department

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

Provider Services	
Address:	Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122
Phone:	(866) 472-4585
Fax:	(866) 948-3537

March Vision Care

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

March Vision Care	
Address:	6701 Center Dr. W Suite 790 Los Angeles, CA 90045
Phone:	(888) 493-4070

ADI, Doral Dental

Molina Healthcare is contracted with ADI, Doral to provide dental services for our Members. Members who are eligible may directly access ADI, Doral network Provider.

DentaQuest	
Address:	DentaQuest –Claims 12121 North Corporate Parkway Mequon, WI 53092
Phone:	(888) 696-9541

Section 2. Enrollment, Eligibility and Disenrollment

Enrollment in Medicaid Programs

The State of Florida (State) has the sole authority for determining eligibility for Medicaid and whether Medicaid Recipients are mandated to enroll in, may enroll in or may not enroll in Medicaid Reform. The Agency for Health Care Administration (Agency) or its Agent reviews the Florida Medicaid Management Information System (FMMIS) file daily and sends written notification and information to all potential Members. A potential Member has (30) calendar days to select a health plan. If the Member does not choose a plan, the Agency or its Agent will auto-assign the Member to a health plan using a pre-established algorithm.

The following groups of Florida Medicaid Recipients are authorized to enroll in a managed care plan:

- Low Income Families and Children
- Sixth Omnibus Budget Reconciliation Act (SOBRA) Children
- Supplemental Security Income (SSI) Medicaid Only
- SSI Medicare, Part B only
- SSI Medicare, Parts A and B
- Medicaid Recipients who are residents in Assisted Living Facilities and are not enrolled in an ALF waiver program
- Refugees
- The Meds AD population
- Individuals with Medicare coverage (e.g., dual eligible individuals) who are not enrolled in a Medicare Advantage Plan
- Title XXI MediKids are eligible for Enrollment in the Health Plan in accordance with Section 409.8132, F.S. Except as otherwise specified the Health Plan contract, Title XXI MediKids eligible participants are entitled to the same conditions and services as currently eligible Title XIX Medicaid Recipients
- Women enrolled in the Health Plan who change eligibility categories to the SOBRA eligibility category due to pregnancy remain eligible for Enrollment in the Health Plan

Only Medicaid Recipients who are included in the eligible population and living in counties with authorized Health Plans are eligible to enroll and receive services from the Health Plan. The Agency or its Agent shall be responsible for Enrollment, including Enrollment into a Health Plan, Disenrollment, and outreach and education activities.

The following Medicaid recipients are not eligible to enroll in a Medicaid managed care plan:

- Recipients who reside in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD); nursing facility, state mental hospital
- Recipients who are under the age of (21) and are enrolled in Children's Medical Services or attend a prescribed pediatric extended care center
- Recipients under (18) who are in a Statewide Inpatient Psychiatric Program (SIPP)
- Recipients who receive hospice services
- Recipients who are enrolled in a Medicare or private HMO or other healthcare insurance such as TRICARE (formerly known as CHAMPUS)
- Recipients who are eligible for limited Medicaid under such programs as the Family Planning waiver; Medically Needy or Qualified Medicare Beneficiary (QMB)

Effective Date of Enrollment

Medicaid Programs: Except for newborns, enrollment with Molina Healthcare is effective as follows:

Enrollment in the Health Plan, whether chosen or Auto-Assigned, is effective at 12:01 a.m. on the first (1st) Calendar Day of the month following potential Member's selection or Auto-Assignment, for those potential members who choose or are Auto-Assigned to the Health Plan on or between the first (1st) Calendar Day of the month and the Penultimate Saturday of the month. For those Members who choose or are Auto-Assigned to the Health Plan between the Sunday after the Penultimate Saturday and before the last Calendar Day of the month, Enrollment in the Health Plan will be effective on the first (1st) Calendar Day of the second (2nd) month after choice or Auto-assignment. The Agency or its Agent will notify the Health Plan of a Member's selection or assignment to the Health Plan.

The Agency or its Agent will send a written confirmation notice to Members identifying the chosen or Auto-Assigned Health Plan. If the Member has not chosen a PCP, the confirmation notice will advise the Member that the Health Plan will assign a PCP.

Conditioned on continued eligibility, Mandatory Members will have Lock-In period of (12) consecutive months. After an initial (90) day change period, Mandatory Members will only be able to disenroll from the Health Plan for cause. The Agency or its Agent will notify Members at least once every (12) months and at least (60) calendar days prior to the date the Lock-In period ends (the Open Enrollment period), that they have the opportunity to change health plans. Members who do not make a choice will be deemed to have chosen to remain with their current health plan, unless the current health plan no longer participates as a Florida Medicaid Health Plan.

The Agency or its Agent will automatically re-enroll a Member into the health plan in which he or she was most recently enrolled if the Member has a temporary loss of eligibility, defined as less than (60) calendar days. In this instance, for Mandatory potential members, the Lock-In period will continue as though there had been no break in eligibility, keeping the original (12) month period.

If a temporary loss of eligibility has caused the Member to miss the Open Enrollment period, the Agency or its Agent will enroll the Member in the health plan in which he or she was enrolled prior to the loss of eligibility. The Member will have (90) calendar days to disenroll without cause.

Newborn Enrollment

A newborn whose mother is enrolled in Molina Healthcare is not automatically enrolled in Molina Healthcare. Molina Healthcare must create an unborn record and Molina Healthcare and the Department of Children and Families must activate the unborn record by completing an activation form.

PCP's are required to notify Molina Healthcare via the Pregnancy Notification Report (included in Appendix B of this manual) immediately of the first prenatal visit and/or positive pregnancy test of any Member presenting themselves for healthcare services. The Health Plan shall notify the appropriate Department of Children and Families Customer Support Center Economic Self-Sufficiency Services of a Member's pregnancy.

Hospitals must notify the Health Plan when a pregnant Member presents to the hospital for delivery. This notification shall take place via the Daily Census Report. Molina Healthcare shall determine if the newborn has a record on the Florida Medicaid Management Information System (FMMIS) that is waiting activation. Upon notification of a Member's delivery, Molina Healthcare shall notify ACS Health State Healthcare of the delivery.

If the pregnant Member presents to a network or non-network hospital for delivery without having an Unborn Eligibility Record on file that is awaiting activation, Molina Healthcare shall immediately initiate action to notify Department of Child Services (DCS) of the pregnancy and/or delivery.

Molina Healthcare is responsible for payment of covered services for each enrolled newborn for up to the first (1st) three (3) months of life, provided the newborn was enrolled through the Unborn Activation Process. If, however, Molina Healthcare was not notified of a Member's pregnancy and the first step of the Unborn Activation Process was not completed before the Member presented to the hospital for delivery, the newborn will not be a Member of Molina Healthcare upon birth. As a result, Molina Healthcare is not responsible for payment of any services rendered to the newborn until such time as the newborn becomes a Member. If the child did not go through the Unborn Activation Process, Molina Healthcare is not responsible for payment of covered services provided by the hospital, the pregnant Member's attending physician and the newborn's attending and consulting physician. Providers must file claims for services provided to the newborn through fee-for-service Medicaid.

Inpatient at time of Enrollment

Regardless of what program or health plan the Member is enrolled in at discharge (DSHS FFS or a Healthy Options plan), the program or plan the member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the member is no longer confined to an acute care hospital.

Eligibility Verification

Medicaid Programs

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

Eligibility Listing for Medicaid Programs

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

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

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

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

- Molina Healthcare Member Services at (866) 472-4585, Press Option 1 for Providers, then Press Option 1 for Member Eligibility
- Molina Healthcare, Inc. e: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.

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

The Florida Medicaid Identification card is a gold plastic card with a magnetically encoded stripe. Recipients who are eligible for MediKids have a blue and white plastic card with a magnetically encoded stripe. 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 provider must submit a claim to the Health Plan using the recipient's ten-digit Medicaid ID number. This number is not on the Medicaid identification card. The eight-digit number on the front of the

Medicaid identification card is the card control number used to access the recipient's file and verify eligibility. It is not the recipient's ten-digit Medicaid identification number that is entered on claims for billing.

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

All Members enrolled with Molina Healthcare receive an identification card from Molina Healthcare in addition to the Florida Medicaid ID card. Molina Healthcare sends an identification card for each family Member covered under the plan. The Molina Healthcare ID card has the name and phone number of the Member's assigned PCP.

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

Disenrollment

Voluntary Disenrollment: Molina Healthcare must not restrict the Member's right to disenroll voluntarily in any way. Neither it nor its agents shall provide or assist in the completion of a Disenrollment request or assist the Agency's contracted Choice Counselor/Enrollment Broker in the Disenrollment process. A Member may submit to the Agency or its Agent a request to disenroll from the Health Plan without cause during the ninety (90) calendar day change period following the date of the Member's initial enrollment with the Health Plan, or the date the Agency or its Agent sends the Member notice of the Enrollment, whichever is later. A Member may request Disenrollment without cause every twelve (12) months thereafter.

A Member may request Disenrollment from Molina Healthcare for cause at any time. Such request shall be submitted to the Agency or its Agent. The following reasons constitute cause for Disenrollment from any health plan:

- The Member moves out of the county, or the Member's address is incorrect and the Member does not live in the county
- The Provider is no longer with the health plan
- The Member is excluded from enrollment
- A substantiated marketing violation occurred
- The Member is prevented from participating in the development of his/her treatment plan
- The Member has an active relationship with a provider who is not on the health plan's network, but is in the network of another health plan
- The Member is enrolled in the wrong Health Plan as determined by the Agency
- The Health Plan no longer participates in the county

- The State has imposed intermediate sanctions upon the Health Plan, as specified in 42 CFR 438.702(a) (3)

- The Member needs related services to be performed concurrently, but not all related services are available within the Health Plan network; or, the Member's PCP has determined that receiving the services separately would subject the Member to unnecessary risk

- The Health Plan does not, because of moral or religious objections, cover the service the Member seeks

- The Member missed his/her Open Enrollment due to a temporary loss of eligibility, defined as sixty (60) days or less

- Other reasons per 42 CFR 438.56(d) (2), including, but not limited to, poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; lack of access to Providers experienced in dealing with the Member's health care needs; or fraudulent Enrollment

Members requesting disenrollment from Molina Healthcare must be referred to the Choice Counselor/Enrollment Broker. Providers should inform Molina Healthcare in writing when a Member has been referred to the Choice Counselor/Enrollment Broker for disenrollment.

Involuntary Disenrollment

Under very limited conditions and in accordance with Agency guidelines, Members may be involuntarily disenrolled from a managed care program. With proper written documentation and approval by the Agency, the following are acceptable reasons for which Molina Healthcare may submit Involuntary Disenrollment requests to the Agency or its Choice Counselor/Enrollment Broker, as specified by the Agency:

- Member has moved out of the Service Area

- Member death

- Determination that the Member is ineligible for Enrollment based on being in an excluded populations

- Fraudulent use of the Member ID card(s)

PCP Dismissal

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

- For a Member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.

- For a Member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her Enrollment in the Health Plan seriously impairs the organization's ability to furnish services to either the Member or other Members. This Section does not apply to Members with mental health diagnoses if the Member's behavior is attributable to the mental illness.

Missed Appointments

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

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

In the event a Member appeals a disenrollment decision through the Agency's appeals process, the Agency may require the plan to continue to provide services to the Member under the terms of the contract pending the final decision. The plan will continue to provide services either by the current PCP or by another medical practice. Should the Member's behavior be a danger or threat to safety or the property of Molina Healthcare, its staff, providers, or other patients, Molina Healthcare will contact the Agency to request an immediate involuntary disenrollment.

PCP Assignment

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

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

PCP Changes

A Member may change the PCP at any time with the change being effective no later than the beginning of the month following the Member's request for the change. If the Member is receiving inpatient

hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital. The guidelines are as follows:

1. If a Member calls to make a PCP change prior to the 15th of the month, the Member will be allowed to retroactively change their PCP to be effective the first of the current month, provided:
    - The Member is new to Molina Healthcare that month.
    - The Member has not received services from any other Provider, including the emergency room (ER).
2. If a Member calls to change the PCP and has been with Molina Healthcare for over (15) days, the PCP change will be made prospectively to the first of the next month.
3. If the Member was assigned to the incorrect PCP due to Molina Healthcare's error, the Member can retroactively change the PCP, effective the first of the current month.

Section 3: Member Rights & Responsibilities

This section explains the rights and responsibilities of Molina Healthcare Members as written in the Molina Member Handbook. Florida law requires that health care providers or health care facilities recognize Member rights while they are receiving medical care and that Members respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. Members may request a copy of the full text of this law from their health care provider or health care facility. Also included in this section is information about providing interpreter services and advance directives to Molina Healthcare Members.

Below are the Member Rights and Responsibilities:

Molina Healthcare Member Rights & Responsibilities Statement

Members have the right to:

- Be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his or her care.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Know what rules and regulations apply to his or her conduct.
- Be given by health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Be able to take part in decisions about his or her health care.
- Have an open discussion about his or her appropriate clinically or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- If eligible for Medicare, to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- Receive information about Molina Healthcare, its services, its practitioners and providers and members' right and responsibilities
- Make recommendations about Molina Healthcare's member rights and responsibilities policies.
- Voice complaints or appeals about the organization or the care it provides.
- Express grievance regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency listed below.

- Office of Civil Rights
  United States Department of Health and Human Services
  105 W. Adams, 16th Floor
  Chicago, Illinois 60603
  (312) 886-2359
  (312) 353-5693 TTY

- Bureau of Civil Rights
  Florida Agency of Health Care Administration
  2727 Mahan Drive
  Tallahassee, FL 32308
  (888) 419-3456

Membership Responsibilities

Members have the responsibility for:

- Providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
- Reporting unexpected changes in his or her condition to the health care provider.
- Reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- Follow the care plan agreed- upon with his or her provider.
- Keeping appointments and, when he or she is unable to do so for any reason, to notify the health care provider or health care facility.
- His or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- Assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- Following health care facility rules and regulations affecting patient care and conduct.
- Understanding his or her health problems and participating in developing mutually agreed-upon treatment goals to the degree possible.

Section 4. Benefits and Covered Services

This section provides an overview of the medical benefits and Covered Services for Molina Healthcare Members. This list is not all inclusive, and some services are subject to benefit limitations. For specific information about a covered service, please contact Member Services at (866) 472- 4585.

Covered Services

Ambulatory Surgery

Birthing Center

Case Management and Disease Management - Available to all members through Molina Healthcare's Utilization Management Department.

Child Health Check-Up (CHCUP) – Refer to CHCUP section of the handbook for additional information.

Chiropractic Services

Dental Services

Dialysis

Durable Medical Equipment

Emergency Services – Refer to Emergency Services section of the handbook for additional information.

Family Planning Services

Hearing Services

Home Health Services

Immunizations – Refer to Immunization section of the handbook for additional information.

Inpatient Hospital Services

Interpreter and Translation Services

Laboratory Services

Licensed Midwife Services

Maternity Services

Mental Health Services

Outpatient Hospital Services

Over-the-counter (OTC) – Non-prescription drugs, up to $25 per household, per month.

Physician Services

Podiatry Services

Portable X-ray Services

Prescribed Drugs

Sterilization – Member must be at least 21 years old, and must complete a State of Florida Sterilization Consent Form at least 30 days prior to the procedure. Other restrictions may apply. Contact Member Services for additional information.

Therapy Services – covered for Members under the age of 21. Members age 21 and older may receive therapy under the Outpatient Hospital Services benefit.

Transplants

Transportation (Emergency and Non-emergency) – Covered in Reform counties only.

Vision Services

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

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

- Emergency services from any emergency care provider
- Family planning services regardless of whether the provider is a plan provider
- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments
- Immunizations by county health departments

Child Health Check-Up (formerly EPSDT)

Child Health Check-Up (CHCUP) is available to every Medicaid-eligible child under age (21). It includes screening (or well-child check-ups), diagnosis and treatment.

To provide Child Health Check-Ups, a provider must be enrolled in Medicaid as a provider with a Category of Service (code 55) for Child Health Check-Ups.

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

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

The Child Health Check-Up schedule is:

- Birth or neonatal examination
- (2-4) days for newborns discharged in less than (48) hours after delivery
- By (1) month
- (2) months
- (4) months
- (6) months
- (9) months
- (12) months
- (15) months
- (18) months
- Once per year for (2) through (20) year olds*

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

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

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

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

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

We need your help conducting these regular exams in order to meet the AHCA targeted state standard. AHCA has a Child Health Check-Up Audit Tool that is required to be completed for all CHCUP exams: http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Child_Health_Check-UpHB.pdf

One of our goals at Molina Healthcare is to improve children's health, as measured by our CHCUP rates. Your help with this effort is essential. If you have questions or suggestions related to well child care and CHCUP regulations, please call our Health Education line at (866) 472-4585.

Vaccines for Children

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

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

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

Immunization Services

Immunization services provide vaccines to induce a state of being immune to or being protected from a disease. Medicaid reimburses these services for recipients from birth through 20 years of age.

Eligible Recipients

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

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

Medicaid does not reimburse for immunization services for recipients who are (21) years of age and older.

Vaccines for Recipients Birth through (18) Years

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

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

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

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

Vaccines for Recipients (19) through (20) Years

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

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, and Rubella (MMR)
- Meningococcal Conjugate (MCV 4)
- Meningococcal Polysaccharide (MPSV4)
- Pneumococcal Polysaccharide (PPV)
- Tetanus and Diphtheria (Td)
- Varicella

Vaccines Excluded from VFC Program

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

Vaccine for Children Program (VFC)

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

Administration Fee Reimbursement

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

Vaccine Reimbursement

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

The provider must bill with the appropriate HCPCS procedure code assigned to the vaccine and a modifier HA when appropriate. CPT codes 90632, 90660, 90733, and 90746 do not require the HA modifier.

Child Health Check-Up

A Child Health Check-Up screening is reimbursable in addition to reimbursement for immunizations.

Evaluation and Management Services

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

Immunization Schedule

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

Procedure Codes and Fees

See the Physician Services Fee Schedule for the procedure codes and fees. The fee schedule is available on the Medicaid fiscal agent website at http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx.. Click on Provider Support, and then click on Fees.

Urgent Care Services

Urgent care services are covered by Molina Healthcare without a referral. This also includes non-contracted providers outside of Molina Healthcare's service area.

(24) Hour Nurse Advice Line

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

Molina Healthcare is committed to helping our Members:

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

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

Enhanced Benefit Rewards Program (Reform County Broward)

Molina Healthcare and Medicaid offer members a reward program for improving their health. Members earn credits to spend on health-related products when they take part in an approved healthy behavior, such as:

- Immunizations for children
- Dental check-ups for children
- Taking prescriptions as directed
- Weight loss programs

Members can earn up to $125.00 in credits per year. The credits can be used at any Florida Medicaid Pharmacy, for example:

- Wal-Mart
- CVS

For additional information on this program, please call:

- Member Services Department at 1-866-472-4585
- (English) TTY at 1-800-955-8771
- (Spanish) TTY at 1-877-955-8773
- Visit ww.molinahealthcare.com

Member Information and Marketing

Any written informational and marketing materials directed at Molina Healthcare Members must be developed at the fourth grade reading level and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials. Neither Molina Healthcare, 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

Disease Management Programs

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

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

A Care Manager/Nurse is on hand to teach your Patient's about their disease (s). He/she will manage the care with their (PCP) and provide other resources. There are many ways a member can identify to participate in these programs. These programs are not meant to replace or interfere with the member's physician assessment and care. Our goal is to partner with you in delivering quality healthcare to our members. Members have the option to opt out at any time.

For more info about our programs, please call:

- Member Services Department at 1-866-472-4585
- (English) TTY at 1-800-955-8771
- (Spanish) TTY at 1-877-955-8773
- Visit www.molinahealthcare.com

Pregnancy Health Management Program

We care about the health of our pregnant members and their babies. Molina's pregnancy program will make sure member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/member the support needed and answer questions you may have. You will be mailed a workbook and other resources are available to the member. The member will also learn ways to stay healthy after child birth. Special care is given to those who have a high-risk pregnancy. It is the member's choice to be in the program. They can choose to be removed from the program at any time. Molina Health Care is requesting your office to complete the pregnancy notification form (refer to page __ for form) and return to us as soon as pregnancy is confirmed. The Motherhood Matters ^{SM} 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. The Motherhood Matters ^{SM} pregnancy management program strives to reduce

hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. The Motherhood Matters [SM] does not replace or interfere with the member's physician assessment and care. The program supports and assists physicians in the delivery of care to members.

Motherhood Matters [SM] Program Activities

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

Additional Motherhood Matters [SM] Program Benefits:

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

- Member Outreach – Motherhood Matters [SM] Program is promoted to members through various means including, program brochures in new member Welcome Packets, other member mailings, Member newsletters, Provider newsletters, posters and brochures placed in practitioner's offices and marketing materials and collaboration with national and local community-based entities.

Health Management Programs

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

Breathe with ease

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

Breathe with ease Program Activities:

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

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

Additional Asthma Program Benefits:

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with asthma. A Registered Nurse (RN) Care Manager calls all patients hospitalized for complications related to asthma. The RN Care Manager completes an assessment of the patient's medical needs and works with the PCP to resolve concerns. A copy of the assessment is then faxed to the PCP's office.
- Clinical Practice Guidelines – Molina Healthcare adopted the NHLBI Asthma Guidelines.
- Asthma Registry – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma Members in the program.
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.
- Asthma Profiles – We send PCPs a report or profile of patients with asthma. This shows specific

patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

Healthy Living with Diabetes

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

The Healthy Living with Diabetes program includes:

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

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

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

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

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

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

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

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

To find out more information about the disease management programs, please call Member Services Department at 1-866-472-4585.

Section 5. Transportation

Reform County Only

Non-Emergency Medical Transportation

Molina Healthcare provides Non-Emergency Medical Transportation in Broward County.

If a Broward County Member is in need of this service, please have them call Logisticare's reservation line for Molina members at (866) 528-0454.

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

Non emergency transportation requires prior approval and must be scheduled in advance.

Non Reform

Transportation in non-reform counties is not covered by Molina Healthcare, but is billable to the State. If you need to assist your patient in scheduling transportation services, please contact your local Medicaid area office.

Section 6. Provider Responsibilities

This section describes Molina Healthcare's established standards on access to care, office sites, medical record documentation, Member confidentiality, 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
- Sexual orientation
- Marital status
- Physical
- 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, Molina Healthcare must receive (30) days advance notice from the Provider.

Access to Care Standards

Molina Healthcare is committed to providing timely access to care for all Members in a safe and healthy environment. Molina Healthcare 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 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. Molina Healthcare will monitor appointment access waiting time annually. Providers that are not in compliance will be placed on a Corrective Action Plan (CAP).

Type of Care	Appointment Wait Time
Preventive Care Appointment	Within (30) days of request
Routine Care	Within seven days of request
Urgent Care	Within (24) hours
Emergency Care	Available by phone (24) hours/seven days
After-Hours Care	Available by phone (24) hours/seven days
Office Waiting Time	Should not exceed (30) minutes

PCP Responsibilities

- Coordinate and supervise the delivery and transition of care to for each assigned Member.
- Ensure newly enrolled Members receive an initial health assessment no later than one-hundred eighty (180) days following the date of enrollment and assignment to the PCP.
- Ensure 24/7/365 availability for members requiring emergency services.
- Ensure appointment access for all Members in accordance with the Access to Care Standards
- Maintain a ratio of 1 FTE licensed practitioner per 1,500 members, and 1 ARNP or PA for every 750 members above 1,500.
- Provide Child Health Check-Ups (CHCUP) in accordance with the periodicity schedule referenced in the CHCUP section of this handbook.
- Provide immunizations in accordance with the Recommended Childhood Immunization Schedule for the US, or when necessary for the Member's health.
- Participate in the Vaccines for Children Program (VFC) for Members 18 years old and younger.
- Provide immunization information to the Department of Children and Families (DCF) upon request by DCF and receipt of the Member's written permission, for members requesting temporary cash assistance.
- Provide adult preventive care screenings in accordance with the U.S. Preventive Services Task Force guidelines
- Utilize Molina Healthcare network providers whenever possible. If services necessary are not available in network, contact Utilization Management for assistance.
- Maintain a procedure for contacting non-compliant Members.
- Ensure Members are aware of the availability of non-emergency transportation in reform counties, and in non-reform counties assist members with transportation scheduling.
- Ensure Members are aware of the availability of free, oral interpretation and translation services, including Members requiring services for the hearing impaired.
- Provide a physical screening within seventy-two (72) hours, or immediately if required, for children taken into protective custody, emergency shelter, or foster care program by DCF.
- Submit timely, complete and accurate encounters for each visit where the PCP sees the Member.
- Submit encounters on a CMS 1500 form.
- Allow access to Molina Healthcare or its designee to inspect office, records, and/or operations when requested.

- Cooperate in investigations, reviews or audits conducted by Molina Healthcare, AHCA, or any other state or federal agency.

Site and Medical Record-Keeping Practice Reviews

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

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

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

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

Adequacy of Medical Record-Keeping Practices

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

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

Improvement Plans/Corrective Action Plans

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

1. Send a letter to the Provider that identifies the compliance issues.

2. Send the Provider helpful information such as forms on which to document problems or medication allergies in the medical record.

3. Request the provider to submit a written corrective action plan to Molina within (30) calendar days.

4. Send notification that another review will be conducted of the office in six months.

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

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

Relocations and Additional Sites

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

Compliance Standards

Provider sites must demonstrate an overall 80% compliance with the site and medical record-keeping practice guidelines listed below. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Review Nurse to ensure correction of the deficiency

Newborn Notification Process

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

The PCP shall submit to Molina Healthcare the Pregnancy Notification Report Form (included in Appendix B) immediately working days 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 Molina Healthcare Member Services.

Site and Medical Record-Keeping Practice Guidelines

Facility

- Molina Healthcare conducts medical record review at all PCP sites that serve (10) or more members
- Each practice site may be reviewed during each (2) year period or will be reviewed at least (1) time every (3) year period
- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis and parking area and walkways demonstrate appropriate maintenance.

- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per physician.

Safety

- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one Cardio Pulmonary Resuscitation (CPR) certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (Fire, Safety, Blood-Borne Pathogens, etc.) is documented for offices with ten or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.

Administration & Confidentiality

- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A Clinical Laboratory Improvement Amendments waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectibles and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Medical Record-Keeping Practices

- Each patient has a separate medical record. Records are stored away from patient areas and preferably locked. Records are available at each patient visit. Archived records are available within (24) hours.
- Pages are securely attached in the medical record. Computer users have individual passwords.
- Medical records are organized by dividers or color-coding when the thickness of the record dictates.

- A chronic problem list is included in the record for all adults and children.
- Allergies (and the lack of allergies) are prominently displayed at the front of the record.
- A complete health history questionnaire or History & Physical is part of the record.
- Health Maintenance forms includes dates of preventive services.
- A medication sheet is included for chronic medications.
- Advance Directives discussions are documented for those (18) years and older.
- Record-keeping is monitored for Quality Improvement and Health Insurance Portability and Accountability Act (HIPAA) compliance.

Medical Record Documentation

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

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

Medical Records are reviewed to assure the following is reflected:

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

Medical Record Retention

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

Confidentiality of Medical Records

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

permitted or required by law.

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

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

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

Site Review Nurse (SRN)

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

Compliance Standards

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

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

Medical Record Documentation Includes:

- Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children (eight and younger), past medical history related to prenatal care, birth, operations and childhood illnesses.
- Significant illnesses and medical conditions are indicated on the problem list. If the patient has

no known chronic problems, this is appropriately noted in the record.

- Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies, this is appropriately noted in the record.
- A working diagnosis is recorded with the clinical findings. SOAP charting format is recommended, but not mandatory when progress notes are written.
- Evidence the patient is not being placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Treatment plans are consistent with diagnoses.
- Referral pattern appears appropriate. Review for under and over utilization.
- Notes from consultants are in the record.
- An immunization record for children is up to date. Appropriate history has been made in the medical record for adults.
- Evidence that preventative screenings and services are utilized in accordance with Molina Healthcare's practice guidelines.
- Patient name and identifying number is on each page of the record.
- The registration form or computer printout contains address, home and work phone number, employer and marital status. An emergency contact should also be designated.
- Staff and provider notes signed with initials or first initial, last name and title.
- Dated entries.
- Records legible to staff in the office other than the provider. Dictation is preferred.
- Appropriate notation concerning tobacco exposure for children of all ages and the use of alcohol, tobacco and substance abuse for patients' (12) years and older. Query history of abuse by the time the patient has been seen three or more times.
- Pertinent history for presenting problem is included.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests are ordered as appropriate by the provider.
- Documentation regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. Include the next preventive care visit when appropriate.
- Previous unresolved problems are addressed in subsequent visits.
- Initials of ordering provider on all reports.
- Explicit follow-up plans for all consults and abnormal lab/imaging results.
- Documentation of appropriate health promotion and disease prevention education. Anticipatory guidance is documented at each well child visit.

Medical Record Standards

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

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

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

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

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

- Identifying information of the member including name, Member identification number, date of birth, sex and legal guardianship (if applicable)
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications (or notation that none are known)
- Dated and signed entries by the appropriate party
- The chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider including behavioral health conditions
- Indicated referrals and studies ordered (e.g., laboratory, x-ray, EKG) and referral reports
- Indicated therapies administered and prescribed including dosages and dates of initial or refill prescriptions
- Name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider
- Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services
- An immunization history
- Information relating to the Member’s use of tobacco products and alcohol/substance abuse
- Summaries of all Emergency Services and Care and Hospital discharges with appropriate medically indicated follow up
- Reflection of the primary language spoken by the member and any translation needs of the member
- Identification of member’s need for communication assistance in the delivery of health care services

- Documentation that the Member was provided with written information concerning the member's rights regarding Advance Directives (end of life wishes DNR (do not resuscitate), written instructions for living will or power of attorney) and whether or not the member has executed an Advance Directive. Neither Molina Healthcare of Florida, Inc., nor any of its Providers shall, as a condition of treatment, require the member execute or waive an Advance Directive

- A release document for each Member authorizing Molina Healthcare of Florida, Inc. to release medical information for facilitation of medical care

Newborn Notification Process

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

The PCP shall submit to Molina Healthcare the Pregnancy Notification Report Form (included in Appendix B) immediately working days 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 Molina Healthcare Member Services.

Section 7. Medical Management

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

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

This section on Referrals, Authorizations, and Utilization Management (UM) describes procedures that apply to directly contracted Molina Healthcare PCPs. All contracted Providers must obtain Molina Healthcare's Authorization for specific services that require prior approval, unless the requesting Provider is contracted with a medical group/IPA granted delegated Utilization Management status (For a list of contracted medical groups/IPAs that are delegated for UM please see section (14) of this manual). If you are treating a Member assigned to a PCP in one of the delegated medical groups/IPAs, Molina Healthcare Providers are required to follow their specific Referral and Authorization requirements, as they may restrict their Referrals to Providers within their group.

Utilization Management – Referral Process

Prospective review is a process performed by the UM staff to evaluate Referrals for specified services or procedures. Determinations are made by specially trained personnel based on medical necessity and appropriateness, and reflect the application of Molina Healthcare's approved review criteria and guidelines. Any denial of services may only be issued by the Medical Director (including for services denied because of benefit limitations).

Referral versus Prior Authorization

Referrals are made when medically necessary services are beyond the scope of the PCP's practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a Specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the Specialist. Except for some benefits such as routine eye exams and women's health care needs, Members are required to obtain referrals from their PCPs for specialty care services. Specialists may refer Members to other Specialists or for ancillary services. Referrals and authorizations do not have to be routed back through the PCP. Certain Referrals require a prior authorization from Molina Healthcare for payment of claims.

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

Molina Healthcare's Prior Authorization guidelines are available on our website at:

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

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

Providers should send requests for prior authorizations to the Utilization Management Department by

phone or fax based on the urgency of the requested service. Providers may also submit authorization requests through Molina Healthcare's e-portal at www.molinahealthcare.com. Contact information is listed below.

Phone: (866) 472-4585

Fax: (866) 440-9791

Providers are encouraged to use the Molina Healthcare Service Request Form (included in Appendix B of this manual). If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)
- Provider demographic information (referring Provider and referred Specialist)
- Requested service/procedure, including specific **CPT/HCPCS Codes**
- Member diagnosis (**ICD-9 Code and description**)
- Clinical indications necessitating service or Referral
- Pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inpatient requests)

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

Molina Healthcare will process any non-urgent requests within fourteen (14) working days after receiving adequate clinical information. Urgent requests will be processed within (72) hours or three (3) working days. If a Referral has been previously approved, the Specialist or vendor may call Molina Healthcare directly to request an extension of services. Information generally required to support the decision-making process includes:

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

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (866) 472-4585.

Wrong Site Surgery

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

Avoiding Conflict of Interest

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

Molina Healthcare does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage UM 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.

Coordination of Care

Molina Healthcare's 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.

Molina Healthcare staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate Specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina Healthcare staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

Continuity of Care

Molina Healthcare Members involved in an active course of treatment have the option to complete treatment with the Provider who initiated care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina Healthcare and a Provider will not interfere with this option. 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, Molina Healthcare 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 Utilization Management at the phone number and address listed at the beginning of this section. All requests will be reviewed by the Medical Director. Molina Healthcare 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 Molina Healthcare 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 Molina Healthcare

Continuity and Coordination of Provider Communication

Molina Healthcare stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between Specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Case Management

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

The Molina Healthcare case managers are licensed Registered Nurses (RNs) and are educated, trained and experienced in the case management process. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The CM program is individualized to accommodate a Member's needs with collaboration and approval from the Member's PCP. The Molina Healthcare case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare case manager is responsible for assessing the Member's appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Case Management: Members with high-risk medical conditions may be referred by their PCP or specialty care Provider to the CM program. The case manager works collaboratively with all members of the health care team, including the PCP, hospital UM staff, discharge planners, 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 being referred.

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

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

- Children with Special Health Care Needs

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

Phone: (866) 472-4585

Fax: (866) 440-9791

PCP Responsibilities in Case Management Referrals

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

Case Manager Responsibilities

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

- 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

Health Education and Disease Management Programs

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

Emergency Services

Emergency services are covered twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (365) days a year, for all Members experiencing an emergency medical situation, and do not require authorization. Please refer to **Section 10. Hospitals** for additional information on Emergency Services.

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

Medical Necessity Standards

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered to meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Be 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
- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Be 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
- Be furnished in a manner not primarily intended for the convenience of the Member the Member's caretaker or the provider

Medically Necessary services furnished in a Hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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

CareMark Specialty Pharmaceuticals

Molina Healthcare contracts with CareMark Specialty Pharmacy Services to provide an innovative injectable drug delivery program. This service eliminates the cost associated with stocking and billing for office administered specialty injectable drugs for Molina Healthcare Members.

CareMark operates as a business unit within McKesson Health Solutions. Some of the specialty injectable drugs provided by CareMark are:

- Remicade
- Enbrel
- Lupron
- Interferons

When a Molina Healthcare Member needs an injectable medication, the prior authorization request can be submitted to Molina Healthcare by fax at (866) 236-8531. CareMark will coordinate with Molina Healthcare and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member, and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Section 8. Quality Improvement

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

Quality Improvement Program Goals

- Design and maintain programs that improve the care and service outcomes within identified Member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.

- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, Member safety and service.

- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to Members.

- Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process, and outcomes.

- Using feedback from stakeholders, improve reporting methods to make information available, relevant and timely.

- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals, improve organizational communication and ensure participation of contracted community providers in clinical aspects of programs and services.

- Facilitate organizational efforts to achieve and maintain regulatory compliance and to continually review practices to ensure compliance with standards and contractual requirements.

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

- Health Management Programs; breathe with ease for Asthma, Healthy Living with Diabetes, Motherhood Matters high risk pregnancy program

- Preventive Care and Clinical Practice Guidelines

- Measurement of Clinical and Service Quality; HEDIS, CAHPS® (Consumer Assessment of Health plan Survey), Provider Satisfaction Survey, and Key Quality Metrics

Preventive Care and Clinical Practice Guidelines

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

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

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

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

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

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

Guidelines are reviewed annually and updated as appropriate. If you would like a printed copy of the guidelines, you may request it by calling our Health Education Line at (866) 472-4585.

Measurement of Clinical and Service Quality:

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

HEDIS

Molina Healthcare utilizes NCQA HEDIS as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS is conducted annually in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, appropriate use of asthma medications, and prenatal and postpartum care.

HEDIS results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare's clinical quality improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs. These activities include Molina Healthcare's diabetic and asthma health management programs, childhood and adolescent well-child and immunization program, and prenatal and postpartum care programs.

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

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

CAHPS®

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

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

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

Molina Healthcare monitors the effectiveness of clinical and service activities through metrics selected

to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating a best practice. The Clinical Quality Improvement Committee (CQIC), which includes Members from the Provider network, evaluates clinical metrics on an ongoing basis. Results of these measurements guide activities for the successive periods.

Clinical Metrics include but are not limited to the following:

- Clinical Practice Guideline Compliance measurement:
  - HEDIS measures for asthma, diabetes, and chlamydia screening
  - Use of short-acting beta-agonists for Members with asthma
  - Follow-up Chlamydia testing after positive result and treatment
  - Use of antibiotics for upper respiratory disease
- Effectiveness of interventions in breathe with ease, Healthy Living with Diabetes, Heart Healthy Living, Chronic Obstruct Pulmonary Disease (COPD) programs:
  - Post-hospital follow-up rate with PCP or Specialist
  - Inpatient and emergency department utilization
  - Readmission after primary diagnosis of asthma, diabetes, COPD or a cardiovascular condition
  - Key clinical metrics including but not limited to: annual hemoglobin A1C and eye exams for diabetics and beta-blocker use and cholesterol testing after an acute cardiac event
- Service Improvement Metrics include but are not limited to:
  - UM authorization turnaround times
  - Pharmacy authorization turnaround times
  - Member Services response time
  - Satisfaction with Molina Healthcare specialty network (as measured through CAHPS® and Provider Satisfaction Survey)

Preventive health, Health Education and Incentive Programs

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

If you have any questions regarding these programs, please call our Health Education Line at (866) 472-4585.

Quality Enhancement Program

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

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

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

Molina Healthcare of Florida, Inc. offer Quality Enhancements (QE) to enrollees as specified below.

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

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

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

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

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

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

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

- Children's programs shall promote increased use of prevention and early intervention services for at-risk enrollees. Molina Healthcare, Inc. shall approve claims for the services that are recommended by early intervention Program when they are covered services and Medically Necessary.
- Molina Healthcare, Inc. offers annual training to providers that promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.

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

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

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

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

6 Substance Abuse- Molina Healthcare of Florida, Inc. offers annual Substance Abuse screening training to its contracted Providers.

- PCPs are required to screen Members for signs of Substance Abuse as part of prevention evaluation at the following times:
    - Initial contact with a new enrollee;
    - Routine physical examinations;
    - Initial prenatal contact;
    - When the Member evidences serious over-utilization of medical, surgical, trauma or emergency services; and
    - When documentation of emergency room visits suggests the need.

- Molina Healthcare of Florida, Inc. offers targeted Members either community or Plan sponsored Substance Abuse Programs.

Section 9. Claims

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

- Claim Submission
- Claim Corrections/Adjustments
- Overpayments/Refund Requests
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Billing the Member

Molina Healthcare generally follows AHCA guidelines for claims processing and payment. These guidelines are contained in the AHCA Provider Handbooks.

Claim Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically for CMS-1500 claims 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 Molina Healthcare ID card (Refer to Section 2). Providers billing Molina Healthcare directly should send claims to:

Molina Healthcare of Florida, Inc.
Attn: Claims
P.O. Box 22812
Long Beach, CA 90801

Providers billing Molina Healthcare electronically should use Emdeon payor ID number **51062.** Providers must use good faith effort to bill Molina Healthcare for services with the most current coding (ICD-9, CPT, HCPCS etc.) available. The following information must be included on every claim:

- Member name, date of birth and ID number or PIC number
- Date(s) of service
- ICD-9 diagnosis and procedure codes
- Revenue, CPT or HCPCS code for service or item provided
- Billed charges for service provided
- Place and type of service code
- Days or units, as applicable
- Provider tax identification and NPI number
- Provider name and address

When presenting a claim for payment to Molina Heatlhcare, contracted providers are indicating an understanding that the provider has an affirmative duty to supervise the provision of, and be responsible for, the covered services claimed to have been provided, to supervise and be responsible

for preparation and submission of the claim, and to present a claim that is true and accurate and that is for Molina Healthcare covered services that:

- Have actually been furnished to the member by the provider submitting the claim; and
- Are medically necessary.

NPI Requirement

National Provider Identifier (NPI); Providers must report any changes in their NPI or subparts to Molina Healthcare within (30) 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. Molina Healthcare 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. For Hospital claim submission instructions, please see **Section 10. Hospitals**.

Electronic Claim Submissions

Molina Healthcare also accepts electronic claim submissions for CMS-1500 claims/encounters and UB-04 claims. Please use Molina Healthcare's Emdeon Payor ID number - **51062**. 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 you clearing house within five to seven business days of your transmission
- You should contact your local clearinghouse representative if you experience any problems with your transmission

Timely Claim Filing

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

Timely Claim Processing: The Plan will reimburse providers for the delivery of services pursuant to section 641.3155 F.S., 42 CRF 447.45, and 42 CFR 447.46 including, but not limited to:

a. The date of claim receipt is the date the Plan receives the claim or electronic notice of the claim at its designated claims receipt location; and

b. The date of Plan claim payment is the date of the check or other form of payment.

Payment is subject to the minimum standards as set forth by AHCA.

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 your manual for more information.

Failure to fully cooperate in investigations, reviews or audits conducted by Molina Healthcare, AHCA, Medicaid Fraud Control Unit, or any other state or federal entity, including but not limited to allowing access to the premises, allowing access to Medicaid-related records, or furnishing copies of documentation upon request may constitute a material breach of your Provider Service Agreement and render it immediately terminated.

For additional information on Fraud and Abuse, refer to **Section 12. Fraud and Abuse**.

Claim Editing Process

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

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

Coding edits are generally based on Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative guidelines. If you disagree with an edit please refer to **Section 14. Complaints, Grievance and Appeals Process,** Provider Disputes section.

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the RA and claim information to:

Molina Healthcare of Florida, Inc.
Claims Recovery Department
PO BOX 22812
Long Beach, CA 90801

Coordination of Benefits and Third Party Liability

COB:

HO, SCHIP, BH+ and BH are secondary to all private insurance. Private insurance carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. The provider must include a copy of the other insurance's EOB with the claim. Molina Healthcare will pay patient responsibility from the primary insurance carrier, not to exceed Molina Healthcare's contracted allowable rate (except for BH cost share). Molina Healthcare may request a refund for COB claims paid in error up to (30) months from the original paid date.

Molina Healthcare is required to notify HRSA within (15) working days when a Member is verified to have Dual Coverage with Molina Healthcare and within (60) calendar days when a Member is verified

to have health coverage with any other health carrier. In turn, HRSA provides COB information to Molina Healthcare on a quarterly basis. If HRSA determines the Member's other coverage is comparable to HO, the Member will be prospectively disenrolled from HO and enrolled in fee-for-service Medicaid.

TPL:

Molina Healthcare will pay claims for covered services when probable TPL has not been established or third party benefits are not available to pay a claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

Overpayments and Incorrect Payment Refund Requests

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

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within (35) days after receipt of the claim that is mailed or electronically transferred to the provider.

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

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

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

Billing the Member

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

Encounter Data

Molina Healthcare is authorized to take whatever steps are necessary to ensure that the provider is recognized by the state Medicaid program, including its choice counseling/enrollment broker contractor(s) as a participating provider of the Health Plan and that the provider's submission of encounter data is accepted by the Florida MMIS and/or the state's encounter data warehouse.

Molina Healthcare shall have a comprehensive automated and integrated encounter data system capable of meeting the requirements below:

a. All Molina encounters shall be submitted to the Agency in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional; I - Institutional; D - Dental), and, for pharmacy services, in the National Council for Prescription Drug Programs (NCPDP) format. Health Plan paid amounts must be provided for non-capitated network providers.

b. Molina shall collect, and submit to the Agency's fiscal agent, enrollee service level encounter data for all covered services. Health Plans shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on their behalf.

c. Molina shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.

d. Molina shall provide complete and accurate encounters to the Agency. Health plans will implement review procedures to validate encounter data submitted by providers.

(1) Complete: Molina Healthcare will submit encounters that represent at least 95% of the covered services provided by Health Plan providers and non-participating providers. Molina Healthcare shall strive to achieve a 100% complete submission rate.

(2) Accurate (X12): 95% of the records in a Molina Healthcare's encounter batch submission pass X12 EDI compliance edits and the FMMIS threshold and repairable compliance edits. The X12 EDI compliance edits are established through SNIP levels 1 through 4. FMMIS threshold and repairable edits that report exceptions are defined in the MEDS X12 Companion Guide.

(3) Accurate (NCPDP): 95% of the records in a Molina Healthcare's encounter batch submission pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the National Council for Prescription Drug Programs Telecommunications Standard Guides. Pharmacy benefits system threshold and repairable edits that report exceptions are defined in the MEDS Pharmacy Claims Companion Guide.

Section 10. Hospitals

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

Emergency Services

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

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

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

Molina Healthcare shall not:

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

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

The physician, or the appropriate personnel, shall indicate on the Member's chart the results of all screenings, examinations and evaluations.
Molina Healthcare shall cover all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the Member's condition is an emergency medical condition.

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

or Molina Healthcare, if the Health Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, do not know the Member's PCP, or have been unable to contact the PCP, the hospital must notify the Health Plan as soon as possible before discharging the Member from the emergency care area, or notify Molina Healthcare within twenty-four (24) hours or on the next business day after the Member's inpatient admission.

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

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

Post-Stabilization Care Services

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

- Post-stabilization care services that were pre-approved by the Health Plan.
- Post-stabilization care services that were not pre-approved by the Health Plan because the Health Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request.
- The treating provider could not contact the Health Plan for pre-approval.

Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Health Plan can choose not to cover them if they are provided by a non-participating provider, except in those circumstances detailed above.

Admissions

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

Newborn Reporting Requirements

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

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

Claims Submission

Claims may be submitted to Molina Healthcare with appropriate documentation by mail or electronically. For Members assigned to a delegated medical group/IPA that pays their own claims, please verify the "Remit To" address on the Member's Molina Healthcare ID card (See section 2). Providers billing Molina Healthcare directly should send their claims to:

Molina Healthcare of Florida, Inc.
Attn: Claims
P.O. Box 22812
Long Beach, CA 90801

Providers billing Molina Healthcare electronically should use Emdeon EDI payor ID number: **51062**

As a minimum, the following information must be included on every UB-04 form submitted for payment:

- Provider name, address and telephone number
- Provider federal tax ID and NPI number or Medicaid ID number
- Taxonomy number
- Date(s) of service and type of bill code
- Patient name and address
- Patient date of birth and gender
- Patient ten digit Medicaid ID number
- Admission date and hour, type and source of admission
- Discharge hour and patient status code
- Condition codes if applicable
- Occurrence Codes and dates if applicable
- Value Codes if applicable
- For newborns: birth weight in form locator 39-41 (value codes and amounts)
- Member/responsible person name and address
- Type of Bill
- Revenue, CPT and HCPCS codes as applicable
- Service date (required for outpatient claims)
- Billed charges for service provided
- Total charges
- Days or units as applicable
- ICD-9 diagnosis and procedure code

- Attending provider's name/FL license number number/NPI number NPI is optional

Molina Healthcare will only process claims received on the proper claim forms containing the essential data requirements. If claim information is inaccurate, incomplete or illegible, a request will be issued on the provider's RA for additional information. If the claim form is not completed correctly, then the claim will be returned to the provider without it being entered in Molina Healthcare's claims processing system.

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

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Claim Editing Process

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

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

Coding edits are generally based on Current Procedural Terminology (CPT), HRSA and National Correct Code Initiative guidelines. If you disagree with an edit please refer to **Section 14. Complaints, Grievance and Appeals Process,** Provider Disputes section.

Overpayments and Incorrect Payments Refund Requests

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

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within (35) days after receipt of the claim that is mailed or electronically transferred to the provider.

A provider that denies or contests an organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within (35) days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or

contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within (35) days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within (45) days after receipt of the information.

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

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

Billing the Member

Molina Healthcare contracted providers may not bill the Member for any covered benefit. The contract between the provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider. Additionally, contracted providers must not require a copayment for covered services.

If copayments are waived as an expanded benefit, the provider must not charge enrollees copayments for covered services; and

If copayments are not waived as an expanded benefit a notice that the amount paid to providers by the Agency shall be the Medicaid fee schedule amount less any applicable copayments.

Section 11 HIPAA

HIPAA (The Health Insurance Portability and Accountability Act)

Molina Healthcare's Commitment to Patient Privacy

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

Provider/Practitioner Responsibilities

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

Applicable Laws

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

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

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

Uses and Disclosures of PHI

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

Uses and disclosures for TPO apply not only to the Provider/Practitioner's own TPO activities, but also for the TPO of another covered entity[1] Disclosure of PHI by one covered entity to another covered entity, or healthcare provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

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

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

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

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

Written Authorizations

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

A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of
this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Healthcare Providers/Practitioners must allow patients to exercise any of the below-listed rights that apply to the Provider/Practitioner's practice:

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.

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

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 Molina Healthcare.

HIPAA Transactions and Code Sets

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

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

- Remittance advices

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare's website at http://www.molinahealthcare.com for additional information. 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 Molina Healthcare and to any other entity that requires it. Any changes in it's NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Provider/Practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners

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

Section 12. Fraud and Abuse

Molina Healthcare of Florida seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members. Federal and state resources dedicated to the prevention and detection of health care fraud have increased substantially in the past few years as part of the effort to control federal program expenditures. Molina Healthcare of Florida is committed to working with federal and state regulatory and law enforcement agencies to help prevent and detect fraud, and to recover funds paid for fraudulent claims.

Definitions

"Abuse" means 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)

"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)

Deficit Reduction Act

The Deficit Reduction Act of 2005 (DRA) became effective on January 1, 2007. The DRA requires entities that receive or make annual payments of more than $5 million in federal and state healthcare program funds to have written policies that inform employees, contractors, and agents about:

- The federal and state False Claims Acts;
- How providers and entities will prevent and detect fraud, waste, and abuse;
- The rights of employees to be protected as whistleblowers.

In addition, entities are required to educate their employees on these policies. These requirements apply to all entities, including providers, who receive more than $5 million per year in federal and state healthcare program funds.

False Claims Act

The False Claims Act (FCA - 31 USC § 3279) is a federal law that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The FCA 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" means that a person:

- 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 FCA 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.

A person or entity committing a violation of the FCA is subject to civil penalties of not less than $5,500 and not more than $11,000 per violation, plus three times the amount of damages the government sustains and the government's cost of the civil action brought to recover the penalties and damages. In addition, the person or entity may be excluded from participation in federal health programs for a designated period of time or permanently.

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

Whistleblower Protections

To encourage individuals to come forward and report misconduct involving false claims, the FCA includes a "qui tam" or whistleblower provision. This provision essentially allows any person with knowledge of allegedly false claims to the government to file a lawsuit "under seal" in a federal district court on behalf of the government. The lawsuit is kept confidential while the government reviews and investigates the allegations contained in the lawsuit. If the government decides to intervene, the lawsuit is prosecuted by the U.S. Department of Justice. If the government decides not to intervene, the whistleblower can continue with the lawsuit as a private citizen. If the lawsuit is successful and certain legal requirements are met, the whistleblower may receive an award of 15 to 30 percent of the amount recovered. The FFCA also includes a whistleblower provision, with awards of 10 to 30 percent of recoveries to whistleblowers.

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

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

Personal Responsibility and Liability

The FCA and the FFCA contain some language related to personal liability that makes it illegal to:

- Knowingly present or cause to be presented a false claim for payment;
- Knowingly make, use, or cause to be made or used, a false record or statement material to a false claim;
- Knowingly apply for and receive a payment on behalf of another person, except pursuant to a lawful assignment of benefits, and convert that benefit or payment to their own personal use;
- Have possession, custody, or control of property or money used, or to be used, by the government and knowingly deliver, or cause to be delivered, less than all of that money or property;

- Conspire to commit any violation of the FCA.

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

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

Anti-Kickback Statute

The federal Anti-Kickback Statute (42 USC §§13201-7b(b)) prohibits anyone from purposefully offering, soliciting, or receiving anything of value (e. g., cash, free rent, expensive hotel stays and meals, and excessive compensation to be a medical director or consultant) to generate referrals for items or services payable by any federal health care program. In some industries it is acceptable to reward those who refer business, but in federal health programs it is a crime. The statute covers those who pay as well as those who receive kickbacks. Criminal penalties and administrative sanctions for violating the anti-kickback statute include fines, jail terms, and exclusion from participation in federal health care programs. Physicians who pay or accept kickbacks also face penalties of up to $50,000 per kickback plus three times the amount of the remuneration. (For additional information, see the statute and the Physician Education link on the OIG Fraud Prevention and Detection webpage at *http://oig.hhs.gov/fraud.asp*.)

Physician Self-Referral Law

The federal Physician Self-Referral Law (42 USC §1395nn), commonly referred to as the Stark law, prohibits a physician from referring a Medicare or Medicaid patient for a designated health service to an entity in which the physician or an immediate family member has a financial interest, unless the financial interest meets one of the exceptions provided for in law. Designated health services include most ancillary services and inpatient and outpatient hospital services. Proof of specific intent to violate the law is not required. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in federal health programs. (For additional information, see the statute and the Physician Education link on the OIG Fraud Prevention and Detection webpage at *http://oig.hhs.gov/fraud.asp*.)

Examples of Fraud and Abuse

- Paying or receiving kickbacks for member enrollment or service referrals
- Submitting claims for services not rendered and/or falsifying medical records to increase payment
- Double billing services
- Balance billing members
- Billing services separately that should be billed using a single code (unbundling) or adding modifiers when not appropriate to increase payment
- Use of a medical identification card by someone other than the person identified on the card
- Forgery or alteration of a prescription
- Omitting information or providing misleading or false personal information to obtain health care benefits an individual would not otherwise be entitled to
- Participating in schemes that involve collusion between a provider and a member, such as diverting controlled substance medications for street sales

Reporting Fraud and Abuse

You may report suspected cases of fraud and abuse to Molina's Compliance Officer or directly to the Florida Agency for Healthcare Administration (AHCA). You have the right to report your concerns anonymously to either Molina and/or the Health Care Administration Bureau of Managed Care. Remember to include the following information when reporting suspected fraud or abuse:

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

Report to Molina Healthcare of Florida

Molina Healthcare of Florida Confidential Compliance Hotline Voice Mail: 866-606-3889

Email: mhfcompliance@molinahealthcare.com

To submit written report to Molina Healthcare of Florida via mail or fax:

Compliance Officer
Molina Healthcare of Florida
8300 NW 33rd St, Ste 400
Doral, Florida 33122
Confidential Fax: 866-440-8591

Report to the Florida Agency for Health Care Administration

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer compliant Hotline

toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-866-7226 or 850-414-3990). The reward may be up to 25 percent of the amount recovered, or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

Report to the U. S. DHHS, Office of the Inspector General

To report suspected fraud and/or abuse for Medicare or Medicaid, you may:

- Complete a Medicare or Medicaid Fraud and Abuse Complaint form online at: http://oig.hhs.gov/report_fraud/OIGFraudForm.asp
- Toll-free Complaint Hotline Phone: 1-800-447-8477
- Toll-free Complaint Hotline Fax: 1-800-223-8164

- Toll-free TeleType (TTY) Hotline: 1-800-377-4950
- Submit a written report via U.S. Mail to:
  Office of the Inspector General
  Department of Health and Human Services
  ATTN: HOTLINE
  P.O. Box 23489
  Washington, DC 20026

Section 13. Credentialing

The Molina Healthcare Credentialing Department is responsible for performing, tracking or monitoring all aspects of the credentialing and re-credentialing process under the purview of the Quality Management Department for Providers joining or participating in the Molina Healthcare Network. The credentialing process is designed to meet the State of Florida Requirements and NCQA Standards. In accordance with those standards, Molina Healthcare Members will not be referred and/or assigned to you until the credentialing process has been completed on your submitted practitioner application. Molina Healthcare accepts Council for Affordable Quality Healthcare's (CAQH) credentialing information or our standard practitioner application that contains the State of Florida specific profile elements. Molina Healthcare can contract with Medical Groups/ IPAs who have ability to perform the credentialing functions, per NCQA credentialing standards and guidelines allowing us to delegate credentialing privileges.

Credentialing Process

Forms

The following forms are included for your reference in Appendix B of this manual:

- Molina Healthcare of Florida, Inc. Practitioner Application

Evaluation

As an applicant being credentialed or re-credentialed, you are required to submit adequate information that will allow Molina Healthcare to perform a proper evaluation of your:

- Experience
- Background
- Education and training
- Demonstrated ability to perform as a Provider without limitation, including physical and mental health status as allowed by law

Should your application be incomplete in any way, you and/or your Medical Group/IPA will receive a request from Molina Healthcare to provide the needed information within a specified timeline.

Site Review

Site reviews are required for the following Provider offices:

- All Primary Care Practitioners (including, but not limited to General Practice, Family Practice, Pediatrics, Internal Medicine)
- OB/ GYNs
- Women's Health Care Providers
- High Volume Behavioral Health Providers

A review of all office sites at which you may see Molina Healthcare Members will be scheduled as soon as the Credentialing Department receives your application for participation in our network. A score of 80% or higher is required to pass the review for the application process. Your cooperation in working with the site review staff and implementing any corrective action plans for any identified deficiency will expedite a credentialing decision.

Professional Review Committee (PRC)

All Molina Healthcare Providers must be credentialed and approved by the Medical Director and / or PRC in order for their contract to become effective. The Molina Healthcare PRC participants are made up of your professional peers. As soon as your credentials file contains all of the necessary documentation, verifications, medical record and site review findings, it will be submitted for review and/or approval by the PRC. If the PRC determines further information is necessary to evaluate your application, the Credentialing Department will request such information on behalf of the PRC. The PRC may, in its sole discretion, request that you appear for an interview. The Governing Board of Molina Healthcare has delegated the authority to approve and deny applicants to the PRC. The PRC is required to meet no less than quarterly, but generally meets on a monthly basis, to facilitate timely processing of Provider applicant files.

Verification and Approval

The Credentialing Department will verify the following Provider information that includes but is not limited to:

- Current, unrestricted license to practice
- Current, valid Drug Enforcement Agency (DEA) certificate
- Education and training
- Work history from the time of medical school graduation
- Board Certification
- Clinical admitting hospital privileges in good standing
- Current, adequate malpractice liability coverage
- All professional liability claims history
- References (if applicable)
- Appropriate (24) hour coverage
- Identify any disciplinary actions and/or sanctions
- Query the National Practitioner Data Bank (NPDB)

Re-credentialing

Once a Provider or facility is approved for participation in Molina Healthcare's network, re-credentialing is performed every three years. You will receive a re-credentialing application approximately six months before your credentialing period is to expire. The format used is that of a "profile" and only information that may have changed since the last credentialing will be requested. We request that you verify the information on the profile sheet and return it to us within the specified time frame. Failure to return the information will result in administrative termination from the Molina Healthcare network as a non-compliant Provider.

Information that is reviewed as part of the re-credentialing process includes:

- Verifying that our Providers continue to meet the basic qualifications
- Information from reported quality performance issues, such as utilization data, Member satisfaction surveys and customer service reports

Should your DEA, medical license and/or liability insurance coverage expire at some time prior to your next recredentialing date, you and/or your Medical Group/IPA will receive a request for updated information for your credentials file. Failure to provide this information within the specified time will result in automatic suspension and/or termination from the Molina Healthcare network.

Provider's Right to Review: Providers have the right to review their credentials file at any time. The Provider must notify the Molina Healthcare Credentialing Department in writing and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Molina Healthcare Medical Director and the QI/Credentialing 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 are the application, the license and the DEA certificate. Providers may not copy documents that include pieces of information that are confidential in nature, such as the Provider credentialing checklist, the responses from monitoring organizations (i.e. NPDB, Department of Health/Medical Quality Assurance Commission), and verification of hospital privileges letters.

Provider's Right to Notification and Correction of Erroneous Information:

Molina Healthcare shall notify the Provider immediately, in writing, in the event that Molina Healthcare receives information that conflicts with information given by the Provider. Examples include, but are not limited to actions on a license; malpractice claims history or board certification decisions. The notification shall detail the information in question.

The Provider must submit a written response to:

Molina Healthcare of Florida, Inc.
Attention: Credentialing Department
8300 NW 33rd Street, Suite 400
Doral, FL 33122

This response must be sent by the Provider within (30) calendar days of receiving notification from Molina Healthcare. The notification shall detail the information in question. The Provider must explain the discrepancy and may correct any erroneous information or provide any proof that may be available. If the Provider does not respond within (30) calendar days, application processing will be discontinued and network participation will be denied.

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

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 Molina Healthcare and are notified of their right to be informed of the status of their application in this letter. Providers are also notified of their right in the Provider Manual sent to them at the time of initial contracting.

Providers can request to be informed of the status of their application by telephone, mail or email. Molina Healthcare will respond to the request within two working days. Molina Healthcare may share with the Provider the status of the application in the credentialing process. Molina Healthcare does not share with or allow a Provider to review references or recommendations, or other information that is peer-review protected.

Pursuant to section 1128 of the SSA, Molina Healthcare and its Subcontractors may not subcontract with an Excluded Provider/Person. Molina Healthcare and its Subcontractors shall terminate subcontracts immediately when Molina Healthcare and its Subcontractors become aware of such Excluded Provider/Person or when Molina Healthcare and its Subcontractors receive notice from CMS. Molina Healthcare 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 Molina Healthcare and its Subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its Subcontractors shall attach a written explanation to this Agreement.

Corrective Action, Fair Hearing Plan, and Reporting to the Florida Division of Medical Quality Assurance, Department of Health (Licensing Board) and the NPDB:

Providers have the procedural right to appeal in the event that PRC recommendations and actions result in filing a report to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB. The appeal right, Fair Hearing process, and the requirement to report to the Florida Division of Medical Quality Assurance, Department of Health and NPDB are described in Molina Healthcare's Provider Discipline and Fair Hearing Plan. This is included for your reference at the end of this section.

Section 14. Complaints, Grievance and Appeals Process

Molina Healthcare Members or Member's personal representatives have the right to file a complaint, grievance and submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina Healthcare's Member Grievance and Appeals Process.

Member Complaints, Grievance & Appeals Process

If a member is unhappy with the service from Molina Healthcare or providers contracted with Molina Healthcare, they may file a complaint or a formal grievance by contacting Member Services toll-free at 1-866-472-4585. They can also write to us at:

Molina Healthcare of Florida
Attention: Grievance & Appeals Department
P.O. Box 521838
Miami, FL 33152
Doral, FL 33122

Members may also send their written grievance via fax to (877) 508-5748.

Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the member handbook, member newsletters and Molina Healthcare's web site www.molinahealthcare.com. Members are notified of these rights upon enrollment, and annually thereafter.

Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a member in making decisions related to health care or is a legal representative of the member, MHF will treat such person as a personal representative.

The Member/Provider may file a complaint or Grievance within one year (365 days) after the date of occurrence that initiated the grievance. If the Member/Provider registers an informal complaint, Molina Healthcare will attempt to resolve the complaint within 24 hours. If the complaint cannot be resolved, it will be treated as a formal grievance.

The Member/Provider must file an Appeal within thirty (30) calendar days of receipt of the notice of the Health Plan's action.

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

All grievances whether oral or in writing, and Appeals (oral, followed by written confirmation within 10 days of) are documented by the Member Services Department in all appropriate systems., and written acknowledgement is sent to all parties.

Any issues related to a clinical denial and/or appeal of a coverage decision, is referred to the Utilization Management Department to review the medical necessity aspects of the request.

A person not involved in the previous decision-making process reviews the grievance or appeal to determine the resolution. In appeals involving denial of clinical services, health care professionals with appropriate expertise conduct the review. A Medical Director of same or similar specialty who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination will review the appeal and make the determination.

All grievance and appeal requests concerning admissions, continued stay, immediate care issues, or other services for members who have received emergency services but have not been discharged from a facility are granted an Expedited Review. Expedited Reviews are completed as promptly as the medical condition requires, but no later than (72) hours after the request.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) and/or Critical Incidents issues is referred to the Quality Improvement Department for further investigation and handling (See Appendix B for forms). Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

All grievance decisions are made within state established time frames not to exceed ninety (90) calendar days from the day the initial grievance or appeal is received. However, the grievance process time-frame may be extended up to fourteen (14) calendar days if the member voluntarily agrees to an extension. All appeal decisions are made within state established time frames not to exceed thirty (30) calendar days from the day the initial grievance or appeal is received. However, the appeal process time-frame may be extended up to (14) calendar days if the Member voluntarily agrees to an extension

All aspects of the review process are documented and tracked in MHF's core data maintenance application and Grievance and Appeal database.

At any point during the grievance and appeal process, members have the right to request a Medicaid Fair Hearing or an external independent review (IRO). Members also have the right to appear in person and/or appoint a representative to act and speak on the member's behalf at any point in the grievance and appeals process.

If a member is not satisfied with MHF's decision of their grievance or appeal they may request a review by the Beneficiary Assistance Program (BAP). The member has one year from receipt of the decision letter to request a review. If the member files a Medicaid Fair Hearing on their case, they forfeit the right to a BAP review of their case.

Molina Healthcare shall continue the Member's benefits if the Member or the Member's authorized representative submits a request for appeal within ten (10) business days after the notice of the adverse action is mailed, or within ten (10) business days after the intended effective date of the action, whichever is later.

If the final resolution of the appeal is adverse to the Member and the action is upheld, Molina Healthcare may recover the cost of services furnished to the Member while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.

Expedited Appeal

An appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a member's life or materially jeopardize a member's health. A request to expedite may come from the member, a provider, or when MHF feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within (3) calendar days.

Reporting

All Grievance/Appeal data, including practitioner specific data, is reported quarterly to Member/Provider Satisfaction Committee (MPSC) by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee quarterly. Annually, a quantitative/qualitative report will be compiled and presented to MPSC and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement

Appeals and Grievances will be reported to the State quarterly. Those related to Non-traditional Medicaid members and Children with Special Health Care Needs will be reported separately.

Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

MHF will maintain all grievance and related appeal documentation on file for a minimum of six (6) years. In addition to the information documented electronically in Molina Healthcare's core processing system or maintained in other electronic files, MHF will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process.

Second Opinion

If a Member does not agree with their provider's plan of care, they have the right to a second opinion from another provider. Member can call Member Services to find out how to get a second opinion.

Provider Complaints

Molina Healthcare Provider Services representatives are available to assist providers with any issues or concerns regarding the administration of services. Most issues and complaints can be resolved promptly by calling Provider Services at (866) 472-4585 between the hours of 8:30 a.m. to 5:00 p.m., Monday through Friday.

Contracted providers may also register formal complaints at any time, to express dissatisfaction with a Molina Healthcare policy, procedure, administrative function or for any other reason a provider deems appropriate. Complaints, unrelated to claims, may be reported by phone or in writing, within 45 days of the occurrence prompting the complaint. For claims complaints, please refer to Provider Disputes section in this Handbook.

To register a complaint by phone, contact Customer Service at (866) 472-4585.

To register a complaint in writing, send the written request to:

Molina Healthcare of Florida
Attn: Provider Services Manager
8300 NW 33 Street

Suite 400
Miami, FL 33122

All complaints are reviewed confidentially by the Grievance and Appeals Department, using applicable statutory, regulatory and contractual provisions. Most complaints may be resolved immediately. However, if an immediate resolution is not possible, the resolution will be made as expeditiously as is possible, but will not exceed sixty (60) days of receipt of the complaint. The resolution of the complaint is communicated in writing.

Provider Disputes

Molina Healthcare is committed to the timely resolution of all provider disputes relative to claims payment. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a Provider Dispute, providers may contact Customer Service at (866) 472-4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida
Attention: Grievance & Appeals Department
P.O. Box 527540
Miami, Florida 33152-7450

Providers may also send Provider Disputes via fax to (877) 553-6504.

Provider Disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially by the Grievance and Appeals Department, and the outcome will be communicated in writing within sixty (60) days or receipt of the Provider Dispute.

If the Provider Dispute results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Maximus Federal Services State Appeals Process
50 Square Drive
Suite 120
Victor, NY 14564
Tel. (866) 763-6395
Fax (585) 425-5296

Section 15. Medical Group/IPA Operations

This section contains information specific to medical groups and Independent Practice Associations (IPA) contracted with Molina Healthcare to provide medical care to Members, and outlines Molina Healthcare's delegation criteria and capitation reimbursement models. Molina Healthcare will delegate certain administrative responsibilities to the contracted medical group/IPA upon meeting all of Molina Healthcare's delegation criteria. Provider capitation reimbursement models employed by Molina Healthcare range from fee-for-service to full risk capitation.

Delegation of Administrative Functions

Administrative services which may be delegated to IPAs, medical groups, or other organizations include:

- Claims payment
- Credentialing
- Utilization Management (UM)

Credentialing functions may be delegated to capitated or non-capitated entities, which meet NCQA criteria for credentialing functions. UM and/or Claims payment responsibility is generally only delegated to capitated entities.

Note: The Member's Molina Healthcare ID card will identify which group the Member is assigned. If Claims payment and/or UM has been delegated to the group, the ID card will show the delegated group's remit to address and phone number for referrals and prior authorizations (See section 2) where a sample Molina Healthcare ID Card will be shown at a later date.

Delegation Criteria

Molina Healthcare is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted medical groups/IPAs. Molina Healthcare's Delegation Oversight Committee (DOC) must approve all delegation and sub-delegation arrangements.

Credentialing

To be delegated for credentialing, medical groups/IPAs must:

- Be accredited by the National Committee for Quality Assurance (NCQA) for credentialing or pass Molina Healthcare's credentialing pre-assessment, which is based on NCQA credentialing standards, with a score of at least 80%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for credentialing delegates
- Submit timely and complete credentialing reports to Molina Healthcare
- Comply with all applicable federal and state laws

- When key specialists, as defined by Molina Healthcare, contracted with IPA or group terminate, provide Molina Healthcare with a letter of termination according to contractual agreements and the information necessary to notify affected members

Note: If the medical group/IPA sub-delegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA accredited in all ten areas of accreditation. If the medical group/IPA sub-delegates to a hospital credentialing department, the hospital credentialing department must either be NCQA accredited, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited with full compliance in the medical staff service standards.

A medical group/IPA may request credentialing delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the medical group/IPA's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review. Final decision to delegate the credentialing process is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Additional Requirements for Delegated Providers/Practitioners

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

Utilization Management

To be delegated for UM, medical groups/IPAs must:

- Have a UM program that has been operational at least one year prior to delegation
- Be NCQA accredited for utilization management or pass Molina Healthcare's UM pre-assessment, which is based on NCQA credentialing standards, with a score of at least 80%
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for UM delegates
- Submit timely and complete UM delegate reports to Molina Healthcare
- Comply with the standard Transactions and Code Sets requirements for authorization requests and responses using the formats required by HIPAA
- Comply with all applicable federal and state laws

A medical group/IPA may request UM delegation from Molina Healthcare through Molina Healthcare's Provider Services Contract Manager. Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review. Final decision to delegate UM is based on the medical group/IPAs ability to meet Molina Healthcare's standards and criteria for delegation.

Claims

To be delegated for Claims, IPAs and Provider Groups must do the following:

- Have a capitation contract with Molina Healthcare and be in compliance with the financial reserves requirements of the contract
- Be delegated for UM by Molina Healthcare
- Have an automated Claims payment system with eligibility, authorization, and Claims adjudication
- Have a Claims delegation pre-assessment completed by Molina Healthcare to determine compliance with all regulatory requirements for Claims payment, such as the Claims for emergency services, and the payment of interest on Claims not paid within Florida regulated timeframes
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina Healthcare
- Protect the confidentiality of all Claims information as required by law
- Have a system capable of providing Molina Healthcare with the encounter data required by the state in a format readable by Molina Healthcare
- Agree to Molina Healthcare's contract terms and conditions for Claims delegates
- Submit timely and complete Claims delegate reports to Molina Healthcare
- Within (45) days of the end of the month in which care was rendered, provide Molina Healthcare with the encounter data required by the state in a format compliant with HIPAA requirements
- Provide additional information as necessary to load encounter data within (30) days of Molina Healthcare's request
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA
- Comply with all applicable federal and state laws
- When using Molina Healthcare's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina Healthcare's Claims policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims

A medical group/IPA may request Claims delegation from Molina Healthcare through Molina Healthcare's Delegation Manager (or this process can be initiated by the medical group/IPA's Contract Manager). Molina Healthcare will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the DOC for review. Final decision to delegate Claims is based on the medical group/IPA's ability to meet Molina Healthcare's standards and criteria for delegation.

Quality Improvement/Preventive Health Activities:

Molina Healthcare will not delegate quality improvement to Provider organizations. Molina Healthcare will include all network Providers, including those in medical groups/IPAs who are delegated for other functions (Claims, Credentialing, UM) in its quality improvement program activities and preventive health activities. Molina Healthcare encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina Healthcare would appreciate receiving copies of studies conducted or data analyzed as part of the medical group/IPAs quality improvement program.

Delegation Reporting Requirements

Medical groups/IPAs, contracted with Molina Healthcare and delegated for various administrative functions, must submit monthly reports to Molina Healthcare's FTP site within the timeline indicated by the health plan.. For a copy of Molina Healthcare's current delegation reporting requirements, please contact your Molina Healthcare Provider Services Contract Manager.

Section 16. Cultural Competency

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 Cultural Competency Plan describes how the individuals and systems within the Health Maintenance Organization (HMO) 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

Molina engages providers in cultural competency concepts on a regular basis. This is a summary of the Cultural Competency Plan; providers may use links on the Molina website to obtain the full Cultural Competency Plan.

Cultural Competency Programs are offered to providers and staff supporting providers as well – in short, anyone that may interact with a member. Cultural Competency Training programs will also be made available to Community Based Organizations.

Provider training is conducted concurrent with and integrated into provider orientation with annual reinforcement training. Additional training reinforcement accompanies any continuing medical education (CME) programs developed by the health plan and periodically accompanying provider communications. Cultural Notes, monthly newsletter publication, is emailed to Providers detailing 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:

- Written materials – Provider Manual
- Access to enduring reference materials available through the health plan
- Integration of cultural competency concepts into provider communications
- Continuing Medical Education (CME)
- Educational Materials and Electronic Library

Integrated Quality Improvement Processes

The application of the concepts of cultural competency includes ensuring member access to language services such as oral interpreting, written translation and access to programs and services that are congruent with cultural norms. Molina provides oral interpretation 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. Molina notifies plan members of the availability of oral interpretation services and informs them of how to access oral interpretation services. Members are informed that there is no charge for interpreting and translation services. Such congruency with member populations leads to better communication, understanding and member satisfaction.

Program and Policy Review Guidelines

Molina Healthcare of Florida will assess at least every five years at minimum 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 2010
- Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES)

Glossary of Terms

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

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

I Constant availability of medical supervision by attending Provider or other medical staff

II Constant availability of licensed nursing personnel

III Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the Provider

AHCA – Agency for Health Care Administration

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

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a Provider, including but not limited to laboratory services, radiology services, and physical therapy.

Appeal – An oral or written request by a Member or Member's personal representative received at Molina Healthcare for review of an action.

Authorization – Approval obtained by Providers from Molina Healthcare for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

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

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

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

Child Health Check-Up – Early Periodic Screening Diagnosis and Treatment Program

Children With Special Health Care Needs (CSHCN) – Children identified by HRSA as meeting the federal guidelines under Title V of the Social Security Act (SSA). Any child (birth to (18) years of age) with a health or developmental problem requiring more than the usual pediatric health care.

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

Complaint – Any written or oral expression of dissatisfaction.

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

Credentialing – The verification of applicable licenses, certifications, and experience to assure that Provider status be extended only to professional, competent Providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.

Current Procedural Terminology (CPT) Codes – American Medical Association (AMA) approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, Providers' offices and home health care.

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

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

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

Dual Coverage – When a Member is enrolled with two Molina Healthcare plans at the same time.

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

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

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

Encounter Data – Molina Healthcare shall collect, and submit to the Agency's fiscal agent, enrollee service level encounter data for all covered services.

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

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

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

Federally Qualified Health Center (FQHC) – A facility that is:

I Receiving grants under section 329, 330, or 340 of the Public Health Services Act

II Receiving such grants based on the recommendation of AHCA within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant

III A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638)

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

Grievance – An oral or written expression of dissatisfaction by a Member, or representative on behalf of a Member, about any matter other than an action received at Molina Healthcare.

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

HIPAA – Health Insurance Portability and Accountability Act

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

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

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

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

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

Medically Necessary Services – Services that include medical or allied care, goods or services furnished or ordered to meet the following conditions: (a) Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain; (b) Be 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; (c). Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational; (d) Be 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; and (e) Be furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the provider. Medically Necessary for those services furnished in a Hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary or a Covered Service. (HPC Section I.).

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

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare Provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous Member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

Participating Provider – A Provider that has a written agreement with Molina Healthcare to provide services to Members under the terms of their agreement.

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

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

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

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

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

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

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

Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled Members.

Service Area – A geographic area serviced by Molina Healthcare, designated and approved by AHCA.

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

Florida Kidcare/State Children's Health Insurance Plan (SCHIP) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by HRSA.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

Sub-Contract – A written agreement between a health plan and a participating Provider, or between a participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

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

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

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

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

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

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

Appendix B

Molina Healthcare Forms

The following Molina Healthcare forms have been included for your use. Please feel free to make copies as needed.

- Florida Credentialing Application is a 13-page Practitioner Application
- Hysterectomy Acknowledgment Form
- Newborn Activation Form (DCF-ES 2039)
- Pregnancy Notification Form
- Prior Authorization Request Form
- Sterilization Consent Form
- Critical Incident Reporting Form

Molina Healthcare of Florida, Inc.
Practitioner Application

1. INSTRUCTIONS

This form should be:

- **Typed or legibly printed in black or blue ink.**
- Keep a copy of the application on file for future requests.
- If more space is needed than provided on original, attach additional sheets and reference the question being answered.
- *Please do not use abbreviations*.
- If a section does not apply to you, please check the provided box at the top of the section.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.

Please attach c**urrent copies of the following documents with this application:**

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- **Please sign and date page 13** and **answer the three additional questions.**
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

** **All sections must be completed in their entirety.** **

2. PRACTITIONER INFORMATION

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number: ( )	Pager Number/Cell Phone Number: ( )	E-Mail Address:	
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number	☐ Male ☐ Female	Languages spoken by Practitioner	
Have you ever voluntarily opted-out of Medicare? ☐Yes ☐No			

NPI:	Medicare UPIN:	Medicare Number:	Florida Medicaid Number:	L & I Number(s):
Primary Practicing Specialty:		Other specialties:		
Other Professional Interests in Practice, Research, etc.:				

3. PRIMARY PRACTICE INFORMATION

Effective Date at Primary Practice location (MM/YY) _____

Practice Type (Please check all that apply)
☐PCP ☐Specialist ☐Urgent Care ☐Obstetrics ☐PCP and Obstetrics

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐Other_____

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):
Primary Office Street Address:	City: State: Zip Code: Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )
Mailing Address: (if different from above)	
Billing Address: (if different from above)	
Office Manager / Administrator Name:	Administration Telephone Number: ( )
E-mail Address:	Fax Number: ( )
Credentialing Contact (if different from above):	Telephone Number: ( )
E-mail Address:	Fax Number: ( )
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Is the office wheelchair accessible? ☐Yes ☐No If you are a PCP, do you provide OB services? ☐Yes ☐No	Office Hours
Are you accepting new patients? ☐Yes ☐No Have you limited your practice in any way (e.g. 18 years or older?) ☐Yes ☐No If yes, please explain: _____ _____ Do you currently supervise ARNP's or PA's? ☐Yes ☐No If yes, please provide the name and specialty below: _____ _____ Please list languages spoken by office staff: _____ _____	Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday:_____ Do you provide 24-hour coverage? ☐Yes ☐No If no, please explain how your patients obtain advice and care after hours: _____ _____ _____

4. ADDITIONAL PRACTICE INFORMATION

***Please make a copy of this page and complete for each additional location in which you practice

Effective Date at Primary Practice location (MM/YY) _____

Practice Type (Please check all that apply)
☐PCP ☐Specialist ☐Urgent Care ☐Obstetrics ☐PCP and Obstetrics

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐Other _____

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No
If you are a PCP, do you provide OB services? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No
Have you limited your practice in any way (e.g. 18 years or older?)
☐Yes ☐No If yes, please explain:
_____
_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No
If yes, please provide the name and specialty below:
_____
_____

Please list languages spoken by office staff:
_____
_____

Office Hours
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday: _____
Do you provide 24 hour coverage? ☐Yes ☐No
If no, please explain how your patients obtain advice and care after hours:
_____
_____
_____

5. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS (Attach Additional Sheet if Necessary)		
Florida State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

6. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS					
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

7. UNDERGRADUATE EDUCATION (*Do not abbreviate*)		Does Not Apply ☐
College or University Name:	Degree Received(be specific, e.g. BS Biology)	Graduation Date (mm/yyyy)
Mailing Address:	City: State:	Zip Code:
College or University Name:	Degree Received(be specific, e.g. BS Biology)	Graduation Date (mm/yyyy)
Mailing Address:	City: State:	Zip Code:

8. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)			
Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

9. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION				Does Not Apply ☐
Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

10. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

11. RESIDENCIES (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	

12. FELLOWSHIPS (Attach Additional Sheet if Necessary)			Does Not Apply ☐
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	
Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes		☐ No (If "No", please explain on separate sheet.)	

13. BOARD CERTIFICATION				Does Not Apply ☐
Are you board or otherwise professionally certified?				
☐ **Yes** If "Yes", please complete below:	☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
Have you applied for certification other than those indicated above? ☐ Yes ☐ No If so, list certification and date:				
If you participate in a specialty which does not have board certification, please indicate specialty:				

14. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)		
Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, AND OTHER INSTITUTIONAL AFFILIATIONS	Does Not Apply ☐
Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) previous hospital affiliations, (D) current military affiliations, (E) previous military affiliations. (F) In-patient coverage plan **(for those without admitting privileges).** List only affiliations here, list employment in section XVI, Work History.	

A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)	
Name of Primary Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	

Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	
Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow patients at this hospital? ☐Yes ☐ No	

B. HOSPITAL APPLICATIONS IN PROCESS (*Do not abbreviate*)

Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

C. PREVIOUS HOSPITAL AFFILIATIONS (*Do not abbreviate*)

Name of Admitting Hospital:		Department:	
Mailing Address	City, State, Zip	Phone Number:	Fax Number:
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:			
Name of Admitting Hospital:		Department:	
Mailing Address	City, State, Zip	Phone Number:	Fax Number:
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:			

D. CURRENT MILITARY AFFILIATIONS (Do not abbreviate)	
Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

E. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)	
Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

17. Inpatient Coverage Plan (for those without admitting privileges)	Does Not Apply ☐
Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

18. Covering Providers/Call Group			Does Not Apply ☐
Provider Name & Degree	Specialty	Address	Phone Number

19. WORK HISTORY (*Do not abbreviate*)					
Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.					
Name of Current Practice / Employer:	Contact Name: Email:			Telephone Number: ( ) Fax Number: ( )	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)
Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name: Email:			Telephone Number: ( )	
Reason for Leaving:				Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

20. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:		
	From (mm/yyyy):	To (mm/yyyy):

Modification to the wording or format of the Practitioner Application may invalidate the application.

21. PEER REFERENCES			
List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less than three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.			
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	

22. PROFESSIONAL LIABILITY (*Do not abbreviate*)			
A. CURRENT INSURANCE CARRIER:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began:	Expiration Date:
B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)			
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	

23. PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
	c.	Specialty or subspecialty board certification	YES ☐	NO ☐
	d.	Membership on any hospital medical staff	YES ☐	NO ☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO ☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO ☐
	g.	Professional society membership or fellowship	YES ☐	NO ☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO ☐
	i.	Academic Appointment	YES ☐	NO ☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO ☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO ☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO ☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO ☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO ☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO ☐
	b.	Are you currently under governmental investigation?	YES ☐	NO ☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO ☐
2.	Do you have a history of chemical dependency/substance abuse?		YES ☐	NO ☐
3.	Do you have, or have you had in the last two years, any physical condition, or mental health condition that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES ☐	NO ☐
4.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO ☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO ☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?		YES ☐	NO ☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO ☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES ☐	NO ☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO ☐

24. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Does Not Apply ☐
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? $	

25. ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

By submitting this authorization and release of information form, I understand and agree as follows:

I understand and acknowledge that, as an applicant for participating status with Molina Healthcare of Florida, Inc. for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications.

I further understand and acknowledge that Molina Healthcare of Florida, Inc. or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Molina Healthcare of Florida, Inc. as part of the verification and credentialing process.

I authorize all individuals, institutions and entities of organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to Molina Healthcare of Florida, Inc., their staffs and agents.

I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of Molina Healthcare of Florida, Inc. or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations and policies of Molina Healthcare of Florida, Inc.

I agree to abide by the policies, procedures, and or contractual agreements of Molina Healthcare of Florida, Inc. from whom I am seeking initial or recredentialing.

I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of Molina Healthcare of Florida, Inc. where I have membership and/or participation status before initiating judicial action.

I understand that completion and submission of this application/Attestation/Authorization and Release does not automatically grant me membership or participating status with Molina Healthcare of Florida, Inc.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

1.	**Do you have more than 3,000 patients (defined as seen a minimum of (3) times per year) in your practice, including all populations; Medicaid FFS, MSM Network, MHO, Health Plan, Medicare and commercial.**	YES ☐	NO☐
2.	**Are you eligible to become Medicaid provider?**	YES ☐	NO☐
3.	**Are you currently enrolled in the Florida Medicaid fee-for-service program?**	YES ☐	NO☐

ATTESTATION/RELEASE FORM

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

MOLINA HEALTHCARE

FAX (866) 440-9791

Pregnancy Notification Form

Please complete all sections and fax to **Molina** within **(2) working 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 your office information. If you are the PCP, please name the OB/GYN that the member will be using (if you know).

Step 3: Fax form to Molina Healthcare's Motherhood Matters Program at **(866) 440-9791.**

STEP 1: MEMBER INFORMATION

Member's Name:	
Address:	City: State: ZIP:
Member DOB: / /	Phone #: ( ) Alternate Ph.#: ( )
Date of Positive Pregnancy Test: / /	Date of First Prenatal Visit:
LMP (if known):	EDC (if known):

High Risk Condition(s) (if known):

CURRENT PREGNANCY		PAST PREGNANCY	
☐ Hypertension	☐ Excessive Nausea & Vomiting	☐ N/A	
☐ Diabetes	☐ Pre-term labor	☐ Hypertension	☐ Diabetes
☐ Smoking	☐ Multiple Gestation	☐ Pre-term labor	☐ Pre-term delivery
Other:_____		☐ Other problems with Past Pregnancy	

STEP 2: PHYSICIAN INFORMATION

Physician Name:	☐ OB/GYN ☐ PCP
OB/GYN Practitioner's Name and Phone Number:	

STEP 3: FAX TO MOLINA

If you have any questions or need assistance, please contact us at **(866) 472-4585.**

[Original form to remain in member's chart]

PregnancyNotificationForm11.11.docx

STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGMENT FORM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART A - PHYSICIAN STATEMENT:

_____, _____, understand that the Florida
(PRINT PHYSICIAN'S NAME) (PROVIDER NO.)
Medicaid Program shall not allow payment for a hysterectomy unless it is performed pursuant to the federal requirements stated in 42 CFR 441, Subpart F and accordingly Parts A and B of this form are being completed.

The hysterectomy to be performed is not solely for the purpose of rendering the below mentioned recipient permanently incapable of reproducing nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The nonelective hysterectomy is therefore being performed for the following medical reasons:

_____
(ENTER DX AND EXPLAIN IF NECESSARY)

_____

_____

_____

_____ _____
PHYSICIAN'S SIGNATURE DATE

PART B - PATIENT STATEMENT:

It was explained verbally before surgery and in writing by completion of this form to:

_____
(PRINT: RECIPIENT'S FIRST NAME, INITIAL, LAST NAME, MEDICAID I.D. #)

that the hysterectomy to be performed or which was performed would render her permanently incapable of reproducing.

_____ _____
PATIENT'S SIGNATURE OR MARK DATE

Patient's mark must be witnessed by her representative.

_____ _____
INTERPRETER'S SIGNATURE, WHEN NECESSARY DATE

DISTRIBUTION OF COPIES:

ORIGINAL - Retain in patient's medical record at physician's office.
1 COPY - To patient.
Other copies as required - See note below.

NOTE: A copy of this form shall be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.

7/94

STATE OF FLORIDA
STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked
(DOCTOR OR CLINIC)
for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from program receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about these temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on

_____
MONTH DAY YEAR

I, _____, hereby consent

of my own free will be sterilized by _____
DOCTOR
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
SIGNATURE MONTH/DAY/YEAR

You are requested to supply the following information but it is not required:

Race and ethnicity designation (please check)

- ❑ American Indian or Alaska Native
- ❑ Asian or Pacific Islander
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read

him/her the consent form in _____language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
SIGNATURE DATE

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
NAME OF RECIPIENT
consent form, I explained to him/her the nature of the sterilization operation _____. The fact that is intended to be a final and irreversible procedure and the discomfort, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally component. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
SIGNATURE OF PERSON OBTAINING CONSENT DATE

_____
FACILITY

_____
ADDRESS

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ on
NAME OF INDIVIDUAL TO BE STERILIZED
_____. I explained to him/her the
DATE OF STERILIZATION OPERATION

Nature of the sterilization operation _____.

The fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent forms. In these cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested:

- ❑ Premature delivery
- ❑ Individual's expected date of delivery:
- ❑ Emergency abdominal surgery:

(Describe circumstances:)

_____
PHYSICIAN SIGNATURE DATE OF SURGERY

SERVICE REQUEST FORM

For Molina Internal Use Only

Service Request Number*:_____

*(*Please include on Claim)*

Expiration Date:_____/_____/_____

Line of Business: ☐ Medicaid ☐ Other:	
Service is: ☐ Non-Urgent ☐ Urgent (treatment medically necessary w/in 24-72 hrs.)	**Date of Service**: / /

Member Name: (Last, First, MI)	Date of Birth: / /	Member ID: - -
Member Address: (No., Street, City, State, Zip)		Phone Number: ( ) -

REFERAL/SERVICE TYPE REQUESTED:

☐ Inpatient Admission: ☐ Surgical procedure ☐ Requested LOS ☐ Other:	☐ Outpatient Admission: ☐ Diagnostic ☐ DME ☐ Radiology/Imaging ☐ Home Health/Home Infusion ☐ Therapy (PT/OT/ST) ☐ Surgical ☐ Other: _____	☐ Facility:

REQUESTING PROVIDER:	**REFERRING TO PROVIDER:**
Provider Name: (Last, First, MI)	Referring to Provider Name: (Last, First, MI)
Address: (No., Street, City, State, Zip)	Address: (No., Street, City, State, Zip)
Specialty:	Specialty:
Phone Number: ( ) -	Phone Number: ( ) -
FAX Number: ( ) -	FAX Number: ( ) -

SERVICE REQUEST INFORMATION:

IDC-9 Code# / Description:	**CPT Codes / Description:**	**HCPCS Codes / Description:**
/	/	/

Service Requested & Clinical Indications (Include pertinent past medical hx, tx, physical findings; and attach all relevant medical records, test results, etc):

Requesting Practitioner Signature:	Date: / /

MOLINA USE ONLY:

Criteria/guidelines met: ☐ Yes ☐ No	Auth Status: ☐ Approved ☐ Modified ☐ Deferred ☐ Denied
Comments:	
UM Representative Signature:	Date: / / Approved LOS:

MEDICAL DIRECTOR REVIEW:

☐ APPROVED ☐ MODIFIED ☐ DENIED	Comments:
Medical Director Signature:_____	Date: / /

CLAIMS PAYMENT IS CONTINGENT UPON MEMBER ELIGIBILITY FOR DATE(s) OF SERVICE, APPROPRIATE CODING & BENEFIT LIMITATION

Molina Healthcare of Florida, Inc.
Critical Incident Reporting Form

Please submit the completed form to the Molina Healthcare Quality Improvement Department immediately.

I. Facility Information (Form Must Be Typed)

Name of Facility or Campus _____ Address _____

City _____ Zip Code _____ County _____ Telephone Number _____

e-mail Address _____ Fax Number _____

Person Reporting _____ Title _____

II. Patient Information

Patient Name _____ Age _____ Sex _____ Medicaid ☐ Medicare ☐

Patient Identification Number _____ Date of Admission _____

Patient Address _____ Admitting Diagnosis _____

City _____ State _____ Zip Code _____ ICD-9 Code for Admitting Diagnosis _____

III. Incident Information

_____/_____
Incident Date **Time**

Location of Incident:

Facility Unit:
- ☐ Blood Bank
- ☐ CCU
- ☐ Emergency Room
- ☐ ICU
- ☐ Labor/Delivery
- ☐ Facility Campus_____

- ☐ Laboratory
- ☐ Operating Room
- ☐ Outpatient Services
- ☐ Patient Room
- ☐ Radiology
- ☐ Recovery Room
- ☐ Other_____

Other Health Care Provider:
- ☐ Abortion Clinic
- ☐ Ambulatory Surgical Center
- ☐ Assisted Living Facility
- ☐ Doctor's Office
- ☐ Home Health
- ☐ Nursing Home
- ☐ Name of Other Provider_____

Note: If the incident involved a death,
Was the Medical Examiner notified? ☐ Yes ☐ No
Was an autopsy performed? ☐ Yes ☐ No
Name and contact number of the Medical Examiner_____

A) Describe circumstances of the incident (narrative) **(Use additional sheets as necessary for complete response)**

_____

_____

_____

_____

B) ICD-9-CM Codes

Surgical, diagnostic, or treatment procedure being performed at time of incident **(ICD-9 Codes 01-99.9)**	Accident, event, circumstances, or specific agent that caused the injury or event. **(ICD-9 E-Codes)**	Resulting injury **(ICD-9 Codes 800-999.9)**

Confidential and proprietary information
Forward this form and any additional pertinent documentation to the:
QUALITY IMPROVEMENT DEPARTMENT
MOLINA HEALTHCARE OF FLORIDA, INC.
8300 NW 33rd Street, Suite 400, Miami, FL 33122
Phone: 866-472-4585 - Fax: 866-422-6445

C) List any equipment used if directly involved in the incident

D) Outcome of Incident (Please check)

- ☐ Death
- ☐ Fetal death
- ☐ Brain damage
- ☐ Spinal damage
- ☐ Surgical procedure performed on the wrong site
- ☐ Surgical procedure performed on the wrong patient
- ☐ Wrong surgical procedure performed
- ☐ Surgical procedure unrelated to the patient's diagnosis
- ☐ Surgical procedure to remove foreign objects remaining from a surgical procedure
- ☐ Surgical repair of injuries from a planned surgical procedure

E) List license numbers of personnel and the capacity in which they were directly involved with this incident, i.e., ER physician, attending physician, surgeon, etc. (List social security numbers and capacity of unlicensed personnel)

F) List license numbers of witnesses (List social security numbers and capacity of unlicensed personnel)

IV. Analysis and Corrective Action

A) Analysis (apparent cause) of this incident (Use additional sheets as necessary for complete response)

B) Describe corrective or proactive action(s) taken (Use additional sheets as necessary for complete response)

V.

Signature of Person Reporting **Title**

Date

Confidential and proprietary information
Forward this form and any additional pertinent documentation to the:
QUALITY IMPROVEMENT DEPARTMENT
MOLINA HEALTHCARE OF FLORIDA, INC.
8300 NW 33rd Street, Suite 400, Miami, FL 33122
Phone: 866-472-4585 - Fax: 866-422-6445