Provider Handbook
# Molina Healthcare of Florida, Inc. - Provider Handbook

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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.

<table>
<thead>
<tr>
<th>Member Services</th>
</tr>
</thead>
</table>
| 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.

<table>
<thead>
<tr>
<th>Claims</th>
</tr>
</thead>
</table>
| 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.

<table>
<thead>
<tr>
<th>Claims Recovery</th>
</tr>
</thead>
</table>
| 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-verify 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.

<table>
<thead>
<tr>
<th>Credentialing</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
</tr>
<tr>
<td>8300 NW 33rd Street, Suite 400</td>
</tr>
<tr>
<td>Doral, FL 33122</td>
</tr>
<tr>
<td>Phone: (866) 472-4585</td>
</tr>
<tr>
<td>Fax: (866) 422-6445</td>
</tr>
</tbody>
</table>

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 healthcare information. Registered nurses are available (24) hours a day, seven (7) days a week to assess symptoms and help make good healthcare decisions.

<table>
<thead>
<tr>
<th>HEALTHLINE (24-Hour Nurse Advice Line)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Phone: (888) 275-8750</td>
</tr>
<tr>
<td>Spanish Phone: (866) 648-3537</td>
</tr>
<tr>
<td>TTY: (866) 735-2929 (English)</td>
</tr>
<tr>
<td>(866) 833-4703 (Spanish)</td>
</tr>
</tbody>
</table>

Healthcare Services Department

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

<table>
<thead>
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<th>Healthcare Services Authorizations &amp; Inpatient Census</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
</tr>
<tr>
<td>8300 NW 33rd Street, Suite 400</td>
</tr>
<tr>
<td>Doral, FL 33122</td>
</tr>
<tr>
<td>Phone: (866) 472-4585</td>
</tr>
<tr>
<td>Fax: (866) 440-4791 (Medicaid)</td>
</tr>
<tr>
<td>(866) 472-9509 (Florida Medicare)</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Health Education &amp; Management</th>
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<tbody>
<tr>
<td><strong>Address:</strong> Molina Healthcare of Florida</td>
</tr>
<tr>
<td>8300 NW 33rd Street, Suite 400</td>
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<tr>
<td>Doral, FL 33122</td>
</tr>
<tr>
<td><strong>Phone:</strong> (866) 472-4585</td>
</tr>
<tr>
<td><strong>Fax:</strong> (866) 422-6445</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PsychCare</th>
<th>Access Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address:</strong> Psychcare</td>
<td></td>
</tr>
<tr>
<td>Attn: Claims Department</td>
<td></td>
</tr>
<tr>
<td>10200 Sunset Drive</td>
<td></td>
</tr>
<tr>
<td>Miami, FL 33173</td>
<td></td>
</tr>
<tr>
<td><strong>Phone:</strong> 1-855-371-3945</td>
<td></td>
</tr>
<tr>
<td>(24) Hours per day, (365) day per year</td>
<td></td>
</tr>
<tr>
<td><strong>Address:</strong> Access Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Attn: Claims Department</td>
<td></td>
</tr>
<tr>
<td>1221 W. Lakeview Avenue</td>
<td></td>
</tr>
<tr>
<td>Pensacola, FL 32501</td>
<td></td>
</tr>
<tr>
<td><strong>Phone:</strong> 1-866-477-6725</td>
<td></td>
</tr>
<tr>
<td>(24) Hours per day, (365) day per year</td>
<td></td>
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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.

<table>
<thead>
<tr>
<th>Pharmacy Authorizations</th>
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<tbody>
<tr>
<td><strong>Phone:</strong> (800) 791-6856</td>
</tr>
<tr>
<td><strong>Fax:</strong> (866) 236-8531</td>
</tr>
</tbody>
</table>
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.

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<th>Provider Services</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
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<tr>
<td>8300 NW 33rd Street, Suite 400</td>
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<tr>
<td>Doral, FL 33122</td>
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<tr>
<td>Phone: (866) 472-4585</td>
</tr>
<tr>
<td>Fax: (866) 948-3537</td>
</tr>
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</table>

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.

<table>
<thead>
<tr>
<th>March Vision Care</th>
<th>iCare Solutions</th>
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<tbody>
<tr>
<td>* Medicaid Regions 4, 6, 7, 8, 9, and 11</td>
<td>*Medicaid Region 1</td>
</tr>
<tr>
<td>Address: 6701 Center Dr. W</td>
<td></td>
</tr>
<tr>
<td>Suite 790</td>
<td></td>
</tr>
<tr>
<td>Los Angeles, CA 90045</td>
<td></td>
</tr>
<tr>
<td>Phone: (888) 493-4070</td>
<td></td>
</tr>
<tr>
<td>Address: 7352 NW 34th Street</td>
<td></td>
</tr>
<tr>
<td>Miami, Florida 33122</td>
<td></td>
</tr>
<tr>
<td>Phone: (855) 373-7627</td>
<td></td>
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</table>

DentaQuest

Molina Healthcare is contracted with DentaQuest to provide dental services for our Members. Members who are eligible may directly access DentaQuest network Providers.

<table>
<thead>
<tr>
<th>DentaQuest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: DentaQuest – Claims</td>
</tr>
<tr>
<td>12121 North Corporate Parkway</td>
</tr>
<tr>
<td>Mequon, WI 53092</td>
</tr>
<tr>
<td>Phone: (888) 696-9541</td>
</tr>
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Section 2. Enrollment, Eligibility and Disenrollment

Enrollment in Medicaid Programs

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

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

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

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

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

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

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

(1) Temporary Assistance to Needy Families (TANF);
(2) SSI (Aged, Blind and Disabled);
(3) Hospice;
(4) Low Income Families and Children;
(5) Institutional Care;
(6) Medicaid (MEDS) - Sixth Omnibus Budget Reconciliation Act (SOBRA) for children born after 9/30/83 (age 18 to 19);
(7) MEDS AD (SOBRA) for aged and disabled;
(8) Protected Medicaid (aged and disabled);
(9) Dually Eligibles (Medicare and Medicaid -FFS);
(10) Dual Eligibles - Part C – Medicare Advantage Plans Only; and
(11) The Florida Assertive Community Treatment Team (FACT Team).

Recipients in Medically Needy program eligibility categories are required to enroll in a managed care plan as follows:

(1) Medically Needy – Low Income Families and Children Newborns (PEN) - Mandatory;
(2) Medically Need – Non IV-E Foster Care Newborns (PEN) - Mandatory;
(3) Medically Needy – MEDS (SOBRA) for pregnant women Newborns (PEN) - Mandatory;
(4) Medically Needy – Presumptive Newborns (PEN) - Mandatory;
(5) Medically Needy – SSI Medicaid (Aged, Blind and Disabled); and

Certain recipients may voluntarily enroll in a managed care plan to receive services. These recipients are not subject to mandatory open enrollment periods.

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

(1) Presumptively eligible pregnant women;
(2) Family planning waiver;
(3) Women enrolled through the Breast and Cervical Cancer Program;
(4) Emergency shelter/Department of Juvenile Justice (DJJ) residential;
(5) Emergency assistance for aliens;
(6) Qualified Individual (QI) 1;
(7) Qualified Medicare beneficiary (QMB);
(8) Special low-income beneficiaries (SLMB); and
(9) Working disabled.

In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a managed care plan:

(1) Children receiving services in a prescribed pediatric extended care center (PPEC); and
(2) Recipients in the Health Insurance Premium Payment (HIPP) program.
Express Enrollment

Express Enrollment to a managed care plan, has been approved to the Agency to utilize for the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program. The Agency will implement Express Enrollment for recipients mandatory for enrollment in the MMA program effective January 1, 2016 or later.

Express Enrollment will not be utilized for enrollment in the Long-term Care (LTC) program. Express Enrollment will be used for MMA Specialty Plans if the mandatory potential enrollee has an active specialty plan eligibility indicator on file with the Agency.

Express Enrollment and MMA Plans

Applicants may pre-select an MMA plan following submission of their application for Florida Medicaid. The Agency will enroll mandatory potential enrollees in an MMA plan on the effective date of the potential enrollee’s eligibility determination. The Agency will use an established algorithm to assign mandatory potential enrollees who do not select an MMA plan at the time of their Florida Medicaid application. The Agency or its Agent will send a written confirmation notice to Members identifying the 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. For MMA Managed care plans, if the enrollee has not chosen a PCP, the Agency’s confirmation notice will advise the enrollee that a PCP will be assigned by the Managed care plan.

The Agency will inform MMA plans in the daily enrollment file (834) of new enrollees and the enrollee’s plan effective date.

Enrollee Plan Changes

All MMA and LTC SMMC enrollees will have a one hundred-twenty (120)-day period from the date of their initial managed care plan enrollment to change plans. Plan changes will become effective the first day of the following month.

Newborn Enrollment

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 and Ob-Gyn specialists are required to notify Molina Healthcare via the Pregnancy Notification Report immediately of the first prenatal visit and/or positive pregnancy test of any Member presenting themselves for healthcare services. The Managed care plan shall notify the appropriate Department of Children and Families Customer Support Center 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 hospital, the pregnant Member’s attending physician and the newborn’s attending and consulting physicians that the
newborn is an enrollee. At this time, Molina Healthcare shall notify the Department of Children and Families (DCF) for unborn activation and Medicaid Program Integrity (MPI) for its information.

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 Children and Families of the pregnancy and/or delivery. The newborn will automatically become a Molina Healthcare enrollee retroactive to birth.

Inpatient at time of Enrollment
Regardless of what program or managed care plan the Member is enrolled in at discharge, the Managed care plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility services provided from the date of admission until the date the Member is discharged.

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

Eligibility Verification

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

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

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

- Provider Self Services Automated voice response (FaxBack) that generates a report with all the eligibility information for a particular recipient, which is automatically faxed to the provider’s fax machine
- Automated voice response that provides eligibility information using a touch-tone telephone
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response
Providers who contract with Molina Healthcare may verify a Member’s eligibility and/or confirm PCP assignment by using the following:

- Molina Healthcare Member Services at (866) 472-4585

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

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

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

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

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

All Members enrolled with Molina Healthcare receive an identification card from Molina Healthcare in addition to the Florida Medicaid ID card. Molina Healthcare sends an identification card for each family Member covered under the plan. 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**

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

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

Disenrollment for No Cause
A mandatory Member subject to open enrollment may submit to the Agency or its enrollment broker a request to disenroll from Molina Healthcare without cause at the following times:

(1) During a one hundred-twenty (120) days following the enrollee’s express enrollment
(2) At least every twelve (12) months during a recipient’s annual open enrollment period;
(3) If the temporary loss of Medicaid eligibility has caused the enrollee to miss the open enrollment period; the agency will enroll the enrollee in the Manage care plan in which he or she was enrolled before loss of eligibility.
(4) When the Agency or its enrollment broker grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); and
(5) During the thirty (30) days after the enrollee is referred for hospice services in order to enroll in another Managed care plan to access the enrollee’s choice of hospice provider.

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

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

(1) The enrollee does not live in a region where the Managed care plan is authorized to provide services, as indicated in FMMIS.
(2) The provider is no longer with the Managed care plan.
(3) The enrollee is excluded from enrollment.
(4) A substantiated marketing or community outreach violation has occurred.
(5) The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
(6) The enrollee has an active relationship with a provider who is not on the Managed care plan’s panel, but is on the panel of another Managed care plan. “Active relationship” is defined
as having received services from the provider within the six months preceding the disenrollment request.

(7) The enrollee is in the wrong Managed care plan as determined by the Agency.

(8) The Managed care plan no longer participates in the region.

(9) The state has imposed intermediate sanctions upon the Managed care plan, as specified in 42 CFR 438.702(a)(3).

(10) The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed care plan network, or the enrollee’s PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.

(11) The Managed care plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(12) The enrollee missed open enrollment due to a temporary loss of eligibility.

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

Voluntary enrollees may disenroll from Molina Healthcare at any time.

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

(1) Fraudulent use of the enrollee identification (ID) card. In such cases the Managed care plan shall notify MPI of the event.

(2) Falsification of prescriptions by an enrollee. In such cases the Managed care plan shall notify MPI of the event.

(3) The enrollee’s behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the Managed care plan seriously impairs the organization’s ability to furnish services to either the enrollee or other enrollees.

(a) This provision does not apply to enrollees with medical or mental health diagnoses if the enrollee’s behavior is attributable to the diagnoses.
(b) An involuntary disenrollment request related to enrollee behavior must include documentation that the Managed care plan:

(i) Provided the enrollee at least one (1) oral warning and at least one (1) written warning of the full implications of the enrollee’s actions;

(ii) Attempted to educate the enrollee regarding rights and responsibilities;

(iii) Offered assistance through care coordination/case management that would enable the enrollee to comply;

(iv) Determined that the enrollee’s behavior is not related to the enrollee’s medical or mental health condition.

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.
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:

- 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.
- To a prompt and reasonable response to questions and requests.
- To know who is providing medical services and who is responsible for his or her care.
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To know what rules and regulations apply to his or her conduct.
- To be given by health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- To be able to take part in decisions about your health care. To have an open discussion about your medically necessary treatment options for your conditions, regardless of cost or benefit.
- To refuse any treatment, except as otherwise provided by law.
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- If you are 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.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- To treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- To 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.
- To receive information about Molina Healthcare, its services, its practitioners and providers and members’ right and responsibilities.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To request and receive a copy of his or her medical records, and request that they be amended or corrected.
- To be furnished health care services in accordance with federal and state regulations.
• To make recommendations about Molina Healthcare’s member rights and responsibilities policies.
• To voice complaints or appeals about the organization or the care it provides.
• To 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

**Member Responsibilities**

Members have the responsibility for:

• For providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
• For reporting unexpected changes in your condition to the health care provider.
• For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
• To follow the care plan that you have agreed on with your provider.
• For 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.
• For his or her actions if he or she refuses treatment or does not follow the health care provider’s instructions.
• For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
• For following health care facility rules and regulations affecting patient care and conduct.
• To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
Section 4. Benefits and Covered Services

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

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

Covered Services

Advanced Registered Nurse Practitioner services

Ambulance

Ambulatory Surgical Center Services

Assistive Care Services

Behavioral Health Services

Birthing Center and Licensed Midwife Services

Clinic Services, including Rural health Clinics, Federally Qualified Health Centers, County Health Departments

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 Services

Diabetic Supplies and Education

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

Emergency Behavioral Services

Family Planning Services and Supplies

Healthy Start Services

Hearing Services

Home Health Services and Nursing Care

Hospice Services

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

Inpatient Hospital Services

Interpreter and Translation Services

Laboratory and imaging Services

Maternity Services

Medical Supplies, Equipment, Prostheses and Orthoses

Optometric and Vision Services

Outpatient Hospital Services

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

Physician Services

Physician Assistant Services

Podiatry Services

Portable X-ray Services

Prescribed Drug Services

Prosthetic and Orthotics

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 including physical, occupational, speech-language pathology, and respiratory therapies (see Medicaid Therapy Services Coverage and Limitations Handbook and Medicaid Hospital Services Coverage and Limitations Handbook for coverage limitations)

Transplants

Transportation

**Expanded Benefits**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Visits (Non-Pregnant Adults)</td>
<td>Unlimited visits</td>
</tr>
<tr>
<td>Home Health Care (Non-Pregnant Adults)</td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td>Physician Home Visits</td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td>Prenatal/Perinatal Visits</td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Mammograms and obstetric ultrasounds costs excluded from accruing towards the Medicaid outpatient services limitation</td>
</tr>
<tr>
<td>Over-The-Counter (OTC) Medication/Supplies</td>
<td>Twenty-five dollars ($25) per head of household per month</td>
</tr>
<tr>
<td>Adult Dental Services</td>
<td>One (1) basic exam per year; one (1) comprehensive x-ray per year; two (2) cleanings per year; three (3) amalgam fillings for one-two (1-2) surfaces per year; three (3) resin-based composite fillings for one-two (1-2) surfaces per year; one (1) resin-based composite filling for three (3) surfaces per year; two (2) fluoride treatments per year; subject to prior authorization</td>
</tr>
<tr>
<td>Waived Copayments</td>
<td>Enrollees shall not be subject to co-payment charges</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<tr>
<td>Vision Services</td>
<td>Unlimited sets of glasses from a plan-approved selection; one hundred dollars ($100) for upgraded optical lenses or eyeglass frames (including frames outside of the plan-approved selection) per year; subject to medical necessity and prior authorization. Upgrade to polycarbonate lenses; limited to child enrollees; limited to two (2) pairs of lenses per year</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Five Hundred dollars ($500) every three (3) years for an inner-ear hearing aid; subject to prior authorization; limited to adult enrollees</td>
</tr>
<tr>
<td>Newborn Circumcision</td>
<td>Available upon request during initial hospitalization</td>
</tr>
<tr>
<td>Adult Pneumonia Vaccine</td>
<td>One (1) vaccination per lifetime</td>
</tr>
<tr>
<td>Adult Influenza Vaccine</td>
<td>One (1) vaccination per year;</td>
</tr>
<tr>
<td>Adult Shingles Vaccine</td>
<td>One (1) vaccination per lifetime</td>
</tr>
<tr>
<td>Post Discharge Meals</td>
<td>Three (3) meals per day for seven (7) days; subject to prior authorization</td>
</tr>
<tr>
<td>Pet Therapy</td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td>Art Therapy</td>
<td>Unlimited therapy visits, training and/or supplies; subject to prior authorization</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td>Medically Related Lodging and Food</td>
<td>Limited to enrollee and one (1) traveling partner; maximum one hundred and twenty-five dollars ($125) per day when enrollee travels alone; maximum one hundred and sixty-five dollars ($165) per day when enrollee travels with one (1) traveling partner; enrollee must be required to travel more than one hundred and fifty (150) miles from home for medically necessary treatment; overnight stay required; subject to prior authorization</td>
</tr>
</tbody>
</table>
Molina Healthcare will notify affected providers when it makes changes in covered services, including its expanded benefits at least thirty (30) calendar days before the effective date of the change.

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

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

**Child Health Check-Up (formerly EPSDT)**

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

To provide 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; The Well Child Care (WCC) exam (0-18) months is scheduled on a monthly basis, once per year for (2-6) years, and at (7-20) years old. During the CHCUP visit, providers are required to deliver the following:

<table>
<thead>
<tr>
<th>CHCUP Domain</th>
<th>Infants (0-18) months</th>
<th>Children (2-6) years</th>
<th>Adolescents (7-20) years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam and Health History</td>
<td>History</td>
<td>History</td>
<td>History</td>
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<td></td>
<td>Height</td>
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<td>Weight</td>
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<td></td>
<td>Physical exam</td>
<td>Physical exam</td>
<td>Physical exam</td>
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<tr>
<td></td>
<td>(all of these)</td>
<td>(all of these)</td>
<td>(all of these)</td>
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<tr>
<td>Development and Behavior Assessment</td>
<td>Gross motor</td>
<td>Gross motor</td>
<td>Social/emotional</td>
</tr>
<tr>
<td></td>
<td>Fine motor</td>
<td>Fine motor</td>
<td>Regular physical activity</td>
</tr>
<tr>
<td></td>
<td>Social/emotional</td>
<td>Communication</td>
<td>(any one of these)</td>
</tr>
<tr>
<td></td>
<td>Nutritional</td>
<td>Self-help skills</td>
<td></td>
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<tr>
<td></td>
<td>(any one of these)</td>
<td>Cognitive skills</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Social/emotional</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regular physical activity</td>
<td></td>
</tr>
</tbody>
</table>
Since 2003, Health and Recovery Services Administration (HRSA) has used Health Employer Data Information Set (HEDIS) Well-Child and Well-Adolescent measures to assess the health plans’ rates for the number of children with qualifying Early Periodic Screening Diagnosis and Treatment Program EPSDT exams.

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

The form may be found on the AHCA website at:

http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/HANDBOOKS/Child_Health_C heck-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 eighteen (18) years of age are eligible to receive free vaccines through the federal Vaccine for Children (VFC) Program. The provider is reimbursed only for the administration of the vaccine. The vaccine is free to the provider through the Vaccine for Children (VFC) program, Department of Health.

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

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

**Vaccines for Recipients Birth through (18) Years**

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

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

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

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

**Vaccines for Recipients (19) through (20) Years**

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

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

**Vaccines for Recipients (21) Years and Older**

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

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

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.flmms.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabld/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.

**Health Education Programs - Healthy Behaviors**

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

The programs include:

- Smoking Cessation Program
- Pediatric Preventive Care
- Weight Loss Programs
- Alcohol or Substance Abuse Program
- Motherhood Matters Pregnancy Program
Disease Management Programs

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

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

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

For more info about our programs, please call:

- 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’s Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services.

**Breathe with ease**

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

**Breathe with ease Program Activities:**

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

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

**Additional Asthma Program Benefits:**

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

- Clinical Practice Guidelines – Molina Healthcare adopted the NHLBI Asthma Guidelines.
- Asthma Registry – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma Members in the program.
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.
- Asthma Profiles – We send PCPs a report or profile of patients with asthma. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

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

The Healthy Living with Diabetes program includes:

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


- 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**

**Non-Emergency Transportation**

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

To make a reservation for a transportation service, contact Logisticare’s reservation line for Molina Healthcare Members at (866) 528-0454.

If Member needs further assistance, they can also call (866) 472-4585 and a Member Services Representative will assist them with this request.
Section 6. Provider Responsibilities

This section describes Molina Healthcare’s established standards on access to care, office sites, medical record documentation, Member confidentiality, and newborn notification process 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).
<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Appointment</td>
<td>Within one (1) month of request</td>
</tr>
<tr>
<td>Routine Care</td>
<td>Within one (1) week of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within one (1) day of request</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Available by phone twenty-four (24) hours/seven (7) days</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>Available by phone twenty-four (24) hours/seven (7) days</td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>Should not exceed (30) minutes</td>
</tr>
</tbody>
</table>

**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 and assist members with transportation scheduling.

• Ensure Members are aware of the availability of free, oral interpretation and translation services, including Members requiring services for the hearing impaired.

• Provide a physical screening within seventy-two (72) hours, or immediately if required, for children taken into protective custody, emergency shelter, or foster care program by DCF.

• Submit timely, complete and accurate encounters for each visit where the PCP sees the Member.

• Submit encounters on a CMS 1500 form.

• Allow access to Molina Healthcare or its designee to inspect office, records, and/or operations when requested.

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

**Site and Medical Record-Keeping Practice Reviews**

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

New Providers joining a contracted medical group reviewed and found to be 80% or more in compliance with Molina Healthcare site review guidelines will not require another site review. A copy of the medical group’s site and medical record-keeping practices review report will be filed in the Provider’s credentials file and reviewed by the PRC as part of the initial credentialing process.
A standard site-visit survey form is completed at the time of each visit. This form includes the Site and Medical Record Keeping Practice Guidelines outlined below and the thresholds (3 or more complaints) for acceptable performance against the criteria. This includes an assessment of:

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

**Adequacy of Medical Record-Keeping Practices**

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

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

**Improvement Plans/Corrective Action Plans**

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

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

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

**Relocations and Additional Sites**

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

**Compliance Standards**

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.

**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 to 10 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)
- Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Document referral services in enrollees' medical/case records
- Dated and signed entries by the appropriate party
- The chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider including behavioral health conditions
- Studies ordered (e.g., laboratory, x-ray, EKG) and referral reports
- Indicated therapies administered and prescribed including dosages and dates of initial or refill prescriptions
- Name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider
- Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services
- An immunization history
- Information relating to the Member’s use of tobacco products and alcohol/substance abuse
- Summaries of all Emergency Services and Care and Hospital discharges with appropriate medically indicated follow up
- Reflection of the primary language spoken by the member and any translation needs of the member
- Identification of member’s need for communication assistance in the delivery of health care services
Copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13).

Documentation that the Member was provided with written information concerning the member’s right regarding Advance Directives (end of life wishes DNR (do not resuscitate), written instructions for wills, living wills or advance directives and health care powers of attorney) and whether or not the member has executed an Advance Directive. Neither Molina Healthcare nor any of its Providers shall, as a condition of treatment, require the member execute or waive an Advance Directive.

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

Newborn Notification Process

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

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

Reporting Abuse, Neglect and Exploitation

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

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

“Exploitation” of a vulnerable adult means a person who:
1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult’s funds, assets, or property for the benefit of someone other than the vulnerable adult.
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.
“Neglect” of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term “neglect” also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. “Neglect” is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

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

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, (800) 96ABUSE. Additionally, providers must report adverse incidents including events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents to Molina Healthcare no more than twenty-four (24) hours of the incident.

To report a critical incident, provider should fax the Critical Incident Form to (866) 422-6445.

**Member Information and Marketing**

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

**Contracted Providers may not:**

- Offer marketing/appointment forms.
- Make phone calls or direct, urge or attempt to persuade recipients to enroll in the Managed care plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of the Managed care plan.
- Offer anything of value to induce recipients/enrollees to select them as their provider.
- Offer inducements to persuade recipients to enroll in the Managed care plan.
- Conduct health screening as a marketing activity.
- Accept compensation directly or indirectly from the Managed care plan for marketing activities.
- Distribute marketing materials within an exam room setting.
• Furnish to the Managed care plan lists of their Medicaid patients or the membership of any Managed care plan.

Contracted Providers may:

• Provide the names of the Managed care plans with which they participate.

• Make available and/or distribute Managed care plan marketing materials.

Providers are permitted to make available and/or distribute Managed care plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed care plans with which the provider participates.

Providers may distribute printed information provided by the Managed care plan to their patients comparing the benefits of all of the different Managed care plans with which the providers contract. However, the Managed care plan shall ensure that:

(i) Materials do not “rank order” or highlight specific Managed care plans and include only objective information.

(ii) Such materials have the concurrence of all Managed care plans involved in the comparison and are approved by the Agency prior to distribution.

(iii) The Managed care plans identify a lead Managed care plan to coordinate submission of the materials.

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

If a provider agrees to make available and/or distribute Managed care plan marketing materials it should do so knowing it must accept future requests from other Managed care plans with which it participates.

• Refer their patients to other sources of information, such as the Managed care plan, the enrollment broker or the local Medicaid Area Office.

To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

• Share information with patients from the Agency’s website or CMS’ website.

• Announce new or continuing affiliations with the Managed care plan through general advertising (e.g., radio, television, websites).

• Make new affiliation announcements within the first thirty (30) calendar days of the new provider agreement.
• Make one announcement to patients of a new affiliation that names only the Managed care plan when such announcement is conveyed through direct mail, email, or phone.

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

Any affiliation communication materials that include Managed care plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.
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 providers. All contracted providers must obtain Molina Healthcare’s Authorization for specific services that require prior approval.

Utilization Management – Prior Authorization Process

Prospective review is a process performed by the UM staff to evaluate requests for specified services or procedures. Determinations are made by specially trained personnel based on medical necessity and appropriateness, and reflect the application of 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.

While we encourage members to visit their PCP prior to accessing specialty care, a referral is not required prior to a member obtaining care for an in-network specialist.

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

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

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

http://www.molinahealthcare.com/medicaid/providers/FL/forms/Pages/fuf.aspx
A hard copy of the Prior Authorization Guide and Service Request Form are furnished to all participating providers upon credentialing and when revised, or upon request from a provider.

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

Contact information is listed below.

**Phone:** (866) 472-4585  
**Fax:** (866) 440-9791

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

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

Providers may also submit authorization requests through Molina Healthcare’s Web Portal at [www.molinahealthcare.com](http://www.molinahealthcare.com).

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. 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 and subcontractors to avoid this kind of conflict of interest.

Coordination of Care
Molina Healthcare’s Utilization Management, Case Management and Disease Management will work with Providers 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.

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

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

- Prenatal and postpartum care
- Transplant services
- Oncology (Radiation and/or Chemotherapy services from the current round of treatment)
- Full course of therapy Hepatitis C treatment drugs

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

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

Phone: (866) 472-4585
Fax: (866) 440-9791

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

Continuity and Coordination of Provider Communication

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

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

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

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

Section 8. Quality Improvement

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

Quality Improvement Program Goals

- Design and maintain programs that improve the care and service outcomes within identified Member populations, ensuring the relevancy through understanding of the health plan’s demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, Member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to Members.
• Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process, and outcomes.

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

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

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

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, ATP III 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.

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

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

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

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

Molina Healthcare offer Quality Enhancements (QE) to enrollees as specified below.

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

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

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

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

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

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

1 Children’s Programs- Molina Healthcare provides regular general wellness programs targeted specifically toward enrollees from birth to the age of five (5), or an alternative of making a good faith effort to involve the Member in an existing community Children’s Program.
   • Children’s programs shall promote increased use of prevention and early intervention services for at-risk enrollees. Molina Healthcare, Inc. shall approve claims for the services that are recommended by early intervention 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 ensures that Primary Care Providers (PCP) screen Members for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies.
3 Pregnancy Prevention- Molina Healthcare conducts regularly scheduled Pregnancy Prevention Programs or an alternative of making a good faith effort to involve Members in existing community pregnancy prevention programs. The programs are targeted towards teen Members but are open to all Members regardless of age, gender, pregnancy status or parental consent.

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

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

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

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

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

- Molina Healthcare offers targeted Members either community or Plan sponsored Substance Abuse Programs.
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 Coverage and Limitations 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. 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 CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge.

The following information must be included on every claim:

- Member name, date of birth and ID number or PIC number
- Date(s) of service
- 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

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• Provider tax identification and NPI number
• Provider name and address

When presenting a claim for payment to Molina Healthcare, 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.

Claims 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.

Providers may also submit professional claims (CMS-1500) on Molina Healthcare’s Web Portal at www.molinahealthcare.com.

For Hospital claim submission instructions, please see Section 10. Hospitals.

NPI Requirement

Providers must use their NPI on all electronic transactions required under HIPAA and on all claims and encounters (both electronic and paper formats) submitted to Molina Healthcare. For additional information regarding NPI requirements, please see Section 11. HIPAA.

Electronic Claim Submissions

Molina Healthcare accepts electronic claim submissions for CMS-1500 claims/encounters and UB-04 claims. Please use Molina Healthcare’s Emdeon Payor ID number - 51062. Please track electronic transmissions using the clearinghouse’s acknowledgement reports. These reports assure claims are received for processing in a timely manner.

When claims are filed electronically:

• You should receive an acknowledgement from your current clearinghouse
• You should receive an acknowledgement from you clearinghouse within five to seven business days of your transmission
• You should contact your local clearinghouse representative if you experience any problems with your transmission

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Timely Claim Filing

Providers shall promptly submit to Molina Healthcare, claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim, if requested by Molina Healthcare or otherwise required by Molina Healthcare’s policies and procedures. Claims must be submitted by Provider to Molina Healthcare 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 plan. If Molina Healthcare is not the primary payer under coordination of benefits, Provider must submit claims to Molina Healthcare 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 Molina Healthcare 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 CFR 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 handbook 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


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 Remittance Advice 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. 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 enrollment broker as a participating provider of Molina Healthcarre 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:
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. Encounters must include Managed care plan paid amounts and shall be submitted for all providers (capitated and non-capitated).

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.

For any services in which Molina Healthcare has entered into capitation reimbursement arrangements with providers, Molina Healthcare shall comply with this section, above. Molina Healthcare shall require timely submissions from its providers as a condition of the capitation payment.

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.

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 does not exist, the Managed care plan is not required to cover services rendered subsequent to the provider’s determination unless authorized by the Managed care plan.

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

• The Member’s PCP, if known

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

If the hospital, or any of its affiliated providers, 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,

• Notify Molina Healthcare within twenty-four (24) hours or on the next business day after the Member’s inpatient admission.

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

Molina Healthcare shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as Molina Healthcare can safely transport the enrollee to a participating facility. Molina Healthcare may transfer the Member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the Member’s emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.
Post-Stabilization Care Services
Molina Healthcare shall cover post- 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 must ensure that it notifies the Department of Children and Families (DCF) upon notification from the Hospital that a pregnant member has presented to the hospital for delivery.

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

Claims Submission
Claims may be submitted to Molina Healthcare with appropriate documentation by mail or filed electronically for CMS-1500 claims and UB-04 claims. 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 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
- 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.
Providers shall promptly submit to Molina Healthcare, claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare’s policies and procedures. Claims must be submitted by Provider to Molina Healthcare 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 plan. If Molina Healthcare is not the primary payer under coordination of benefits, Provider must submit claims to Health Plan within ninety (90) days after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Health Plan within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

**Claim Editing Process**

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

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


**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, Molina waives copayments as an expanded benefit to its members. Contracted providers must not require a copayment for covered services.
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.

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

Applicable Laws

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

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

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

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

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

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

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

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

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

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

Written Authorizations

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

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.

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](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 its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Provider/Practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters (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, Waste and Abuse

Introduction

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

Mission Statement

Molina Healthcare of Florida regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina Healthcare of Florida has therefore implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

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

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

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

**Florida False Claims Act**

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

**Deficit Reduction Act**

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

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

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

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

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

- Employment reinstatement at the same level of seniority;
- Two times the amount of back pay plus interest;
- Compensation for special damages incurred by the employee as a result of the employer’s inappropriate actions.
Affected entities who fail to comply with the law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina Healthcare will take steps to monitor Molina Healthcare of Florida contracted providers to ensure compliance with the law.

DEFINITIONS

**Fraud:**

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

**Waste:**

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

**Abuse:**

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

**Examples of Fraud, Waste and Abuse by a Provider**

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

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

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

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

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

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

Provider/Practitioner Education

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

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

Review of Provider Claims and Claims System

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

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

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

Cooperating with Special Investigation Unit Activities

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

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

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

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

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

Remember to include the following information when reporting:

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

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

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/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 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General’s Office about keeping your identity confidential and protected.
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.

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.

Level II Background Screening

Providers seeking participation in Molina Healthcare’s network must complete a satisfactory level II background check. Pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid’s fee-for-service program, in accordance with the following:

- Molina Healthcare shall ensure providers not currently enrolled in Medicaid’s fee-for-service program submit fingerprints electronically following the process described on the Agency’s Background Screening website. The Managed care plan shall verify Medicaid eligibility through the background screening system;

- Molina Healthcare shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;
• Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening; and

• Individuals listed in s. 409.907(8)(a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency’s background screening website.

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 Provider’s 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 Handbook 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 (866) 472-4585, Monday – Friday 8 a.m – 7 p.m.. They can also write to us at:

Molina Healthcare of Florida
Attention: Grievance & Appeals Department
P.O. Box 521838
Miami, FL 33152
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 three (3) days after the request.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) and/or Critical Incidents issues is referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.
All grievance decisions are made within state established time frames not to exceed ninety (90) calendar days from the day the initial grievance or appeal is received. However, the grievance process time-frame may be extended up to fourteen (14) calendar days if the Member voluntarily agrees to an extension. All appeal decisions are made within state established time frames not to exceed thirty (30) calendar days from the day the initial grievance or appeal is received. However, the appeal process time-frame may be extended up to (14) calendar days if the Member voluntarily agrees to an extension.

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

Members also have the right to appear in person and/or appoint a representative to act and speak on the Member’s behalf at any point in the grievance and appeals process.

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). To request a Fair Hearing, Members/Member representative, should contact:

Office of Appeals Hearings  
1317 Winewood Blvd.  
Bldg. 5 – Room 255  
Tallahassee, FL 32399-0700  
Phone: 1-850-488-1429  
Fax: 1-850-487-0662

If a Member is not satisfied with Molina Healthcare’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. To request a review by BAP, Members/Member representatives should contact:

Agency for Healthcare Administration  
Beneficiary Assistance Program  
Building 1, MS #26  
2727 Mahan Drive  
Tallahassee, FL 32308  
1-850-412-4502  
1-888-419-3456 (toll-free)

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.
Expeditied Appeal
An appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a Member’s life or materially jeopardize a Member’s health. A request to expedite may come from the Member, a provider, or when Molina Healthcare feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within (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.

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

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

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

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

All complaints are acknowledged within 3 days of receipt, and 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 ninety (90) 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

Molina Healthcare maintains a Cultural Competency Plan to ensure the delivery of culturally competent services and 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 Molina Healthcare 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.

The intent of the Cultural Competency Plan is to ensure the delivery of culturally competent services and provision of Linguistic Access and Disability-related Access to all enrollees including those with limited English Proficiency. The Cultural Competency Plan describes how individuals and systems within the Health Maintenance Organization (HMO) shall effectively provide services to people of all cultures, races, ethnic backgrounds, religions and or disabilities in order to improve quality and eliminate health care disparities.

The cultural competency program is integrated into overall provider orientation training and quality monitoring programs because the training of employees and providers, along with quality monitoring are the cornerstones of successful culturally competent service delivery. 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

Providers, staff supporting providers and Community Based Organizations receive cultural competency training during provider orientation. Molina also offers free online CME program Continuing Medical Education (CME) courses that are accredited for CME credit (AAFP Prescribed credits approved).

Training is delivered through a variety of methods such as:

- Written materials – Provider Handbook
- Access to enduring reference materials available through the health plan
- Continuing Medical Education (CME)
- Educational Materials and Electronic Library (Diverse Populations Care)

Providers may visit our website to obtain a summary or the full version of this plan; or can request a hard copy at no cost by contacting Provider Services at (866) 472-4585.
**Communication Access**

Molina Healthcare offers various oral and written translation services to assist members in communicating with providers, Molina Customer Service representatives and case managers. These services include:

- Oral and written translation services for members with low English proficiency
- Sign Language interpretation services for the hearing impaired
- Member materials in Spanish, Braille or in audio format

Providers may request interpreter services for any Molina Healthcare member, at no cost to the provider or the member, by calling Customer Service at (866) 472-4585. The hearing impaired may use our TTY line (800) 955-8771.

**Program and Policy Review Guidelines**

Molina Healthcare will assess the following information yearly in order to ensure its programs are most effectively meeting the needs of its members and providers.

Molina monitors complaints in respect to member satisfaction in the area of cultural and linguistic needs in an effort to ensure that each is adequately addressed in a timely manner. The Plan will implement performance intervention measures as well as studies in an effort to identify and improve processes and/or outcomes of health care or services.

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment) as available
- Network Assessment annually
- 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
- Annual Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES)
- CAHPS® Results (annually)
• Provider Satisfaction Survey Results (annually)
• PIP Cultural and Linguistic Access to Services

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:

1. Constant availability of medical supervision by attending Provider or other medical staff
2. Constant availability of licensed nursing personnel
3. 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.


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.

Expeditied 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.

Expeditied 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.