NON-PARTICIPATING PROVIDER BILLING GUIDE

Molina Healthcare of Florida Inc. (Molina Healthcare or Molina)

Managed Medical Assistance/Long-Term Care/Specialty Plan

The Non-Participating Provider Billing Guide is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Non-Participating Providers can access the most current Billing Guide at MolinaHealthcare.com.

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1. CONTACT INFORMATION

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

Provider Services Department

The Provider Services department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal or via the IVR.

Phone: (855) 322-4076
Fax: (866) 948-3537
Availity Essentials Portal: www.availity.com/molinahealthcare

Claims Department

Molina strongly encourages Providers to submit Claims electronically (via a clearinghouse or the Availity Essentials portal) whenever possible.

- Access the Availity Essentials portal at www.availity.com/molinahealthcare
- EDI Payer ID 51062

To verify the status of your Claims, please use the Availity Essentials portal. Claims questions can be submitted through the chat feature on the Availity Essentials portal, or by contacting Provider Services.

Claims Recovery Department

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

Claims Recovery correspondence mailing address:

Molina Healthcare of Florida, Inc.
Claims Recovery Department
PO Box 2470
Spokane, WA 99210-2470

Phone: (866) 642-8999

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, report it to Molina. You may do so by contacting the Molina AlertLine or submit an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance section of this Provider Handbook.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.alertline.com

Abuse, Neglect and Exploitation Hotline

To report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult, please contact the Florida Abuse Hotline toll-free at (800)-96ABUSE or (800) 962-2873, or Providers can report online at: https://reportabuse.dcf.state.fl.us/Adult/AdultForm.aspx.

Healthcare Services Department

The Molina Healthcare Services department conducts concurrent review on inpatient cases and processes Prior Authorization requests. The Healthcare Services (HCS) department also performs Care Management for Members who will benefit from Care Management services.

Molina Healthcare of Florida also contracts with some vendors for support of authorization services for Molina members.

All services rendered by non-Participating Providers require an authorization for payment, except for Emergency Services. Prior Authorizations/Service Requests and status checks can be easily managed electronically. For services that fall into the scope of a vendor delegated by Molina, please refer to that vendor section below.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks.
- Ensures HIPAA compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces cost associated with fax and telephonic interactions.

Molina offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Molina via the Availity Essentials Portal.
- Submit requests via 278 transactions. See the EDI transaction section of Molina's website for guidance

Availity Essentials portal: www.availity.com/molinahealthcare

Phone: (855) 322-4076
Fax: (866) 440-4791

Vision Care Vendor

Molina is contracted with iCare Solutions to provide routine vision services and Ophthalmology services for our Members. Members who are eligible may directly access a vision care network Provider. Claims for vision services submitted in error to Molina will be denied for submission to iCare Solutions.

Address:

iCare Solutions
Attn: Claims
7600 Corporate Center Dr
Suite: 200
Miami, FL 33126

Phone: (855) 373-7627

Therapy Vendor (PT/OT/ST)

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

Address:

American Therapy Administrators of FL/Health Network One
PO Box 350590
Fort Lauderdale, FL 33335-0590

Phone: (888) 550-8800

Note: PT/OT/ST services for LTC members will be managed directly through Molina.

Home Health and Durable Medical Equipment Vendor (HH/DME)

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

Address:

Coastal Care Services, Inc.
Attn: Claims Department
7875 NW 12th Street, Suite 200
Doral, FL 33126

Phone: (855) 481-0505

Note: Home Health, Home Infusion and DME services for LTC and Comprehensive (MMA & LTC) members will be managed directly through Molina.

NICU UM/CM Vendor

Molina is contracted with ProgenyHealth LLC, a company dedicated to management of NICU infants. ProgenyHealth is delegated to manage the Medicaid population only for Molina Florida.

Utilization Management: Call (888) 832-2006 and select option 3
Utilization Management Secure Fax Number: (866) 879-0331
Case Management: Call (888) 832-2006 and select option 4
Case Management Secure Fax Number: (855) 834-2567

Transportation Vendor

Molina Healthcare offers its members access to non-emergency transportation through Access2Care (A2C) Transportation.

To make an appointment for a transportation service, members or providers can contact A2C Transportation's reservation line at: MMA/Specialty/LTC: (888) 298-4781

2. PROVIDER RESPONSIBILITES

Provider Enrollment

As outlined in Florida rule 59G-5.020, a Provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered to a Medicaid enrollee, to be eligible to receive reimbursement. Any entity that bills Medicaid, or a Managed Care Organization (MCO) for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must enroll as a Medicaid provider.

Providers not currently enrolled with AHCA for Florida Medicaid should initiate enrollment with AHCA, but still ensure to bill timely while awaiting enrollment determination or notice. Providers can find Medicaid enrollment information at:

http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/Provider_Enrollment_NewMedicaidProviders/tabId/158/Default.aspx?desktopdefault=

National Plan and Provider Enumeration System (NPPES) Data Verification

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

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

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

Balance Billing

In accordance with Florida Rule 59G-1.050, and Florida statute 641.3154, Medicaid enrolled Providers, regardless of whether the provider is under contract with Molina, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a Molina enrollee for payment of services for which Molina is liable.

Provider must accept payment from Molina as payment in full or bill the appropriate responsible party. Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions stated above:

- The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
- The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
- The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Authorizations

When a Molina Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services, a referral may become necessary. Information is to be exchanged between the PCP and in-network specialist to coordinate care of the patient to ensure continuity of care.

Referrals are only available to Providers which are contracted and credentialed (if applicable) with Molina. In the case of urgent and Emergency Services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care, and hospital emergency room. There may be circumstances in which Members may require an out of network Provider for non-emergency services. In that circumstance, a Prior Authorization will be required from Molina except in the case of Emergency Services (please refer to the Healthcare Services section of this Billing Guide).

Referrals are not required for member visits to Molina Providers with the following specialties - Obstetrics and Gynecology, Dermatology, Chiropractic, Behavioral Health, and Podiatry. Members may access these specialties directly.

For additional information please refer to the Health Care Services section of this Billing Guide.

Provider Responsibilities

As a Medicaid enrolled provider, even though not part of Molina's network, Providers are responsible, in accordance with Florida Rule 59G-1.050 to:

1. Provide all services in an ethical, legal, culturally competent manner, free of discrimination against members based on age, race, creed, color, religion, national origin, marital, physical, mental, or socio-economic status.

2. Inform a recipient of his or her responsibility to pay for services that are not covered by Florida Medicaid, and document in the recipient's file that the recipient was informed of his or her liability, prior to rendering each service. Providers not participating with Molina may only seek reimbursement from a Molina Medicaid recipient under the following circumstances:
    a. The recipient is not eligible for Florida Medicaid on the date of service.
    b. The service rendered is not covered by Florida Medicaid, if the Provider seeks reimbursement from all patients for the specific service.
    c. The Provider verifies that the recipient has exceeded the Florida Medicaid coverage.
    d. The recipient is enrolled in a Florida Medicaid managed care plan (plan) and is informed that:
        i. The plan denies authorization for the service.
        ii. The treating provider is not in the plan's provider network (with the exception of emergency services).

3. Not seek reimbursement from recipients for missed appointments.

4. Not seek reimbursement from the recipient if the Provider fails to bill Florida Medicaid correctly and in a timely manner. Providers who submit a claim to Florida Medicaid for reimbursement of a covered service whether the claim has been approved, partially approved, or denied, may not:
    a. Seek reimbursement from the recipient, the recipient's relatives, or any person, or persons, acting as the recipient's designated representative.
    b. File a lien against the recipient, the recipient's parent, legal guardian, or estate.
    c. Apply money received from any non-Florida Medicaid source to charges related to a claim paid by Florida Medicaid (also known as "balance billing").
    d. Turn a recipient's overdue account over to a collection agency, except in circumstances as specified in paragraph (1)(a), above.

5. Refusal of Services/Right to Refuse Services. Providers may limit the number of Florida Medicaid recipients the Provider serves, and accept or reject recipients in accordance with the policies of the facility or practice, except as disallowed under federal anti-discrimination laws.

5. Solicitation (Patient Brokering). Providers may not knowingly solicit, offer, pay, or receive any payment, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for furnishing, or arranging for the furnishing of, any item or service for which payment may be made, in whole or in part, under the Florida Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for, or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Florida Medicaid program.

6. Comply with all federal and state laws regarding confidentiality of member records.

7. 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**

8. Maintain communication with appropriate agencies, such as local police, poison control, and social service agencies to ensure members receive quality care.

Compliance

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

3. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of

1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related
access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability.

Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com or by calling Molina Provider Services at (855) 322-4076.

Nondiscrimination in Healthcare Service Delivery

Molina complies with Section 1557 of the ACA. As a Medicaid Provider, you and your staff should also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557 of the ACA.

At a minimum, that includes the following:

1. You **MAYNOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you can post can be found in the Member Handbook located at MolinaHealthcare.com.

3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in the Member Handbook located at MolinaHealthcare.com.
4. If a Molina Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html; See also, https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.
5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD, 711 civil.rights@MolinaHealthcare.com If you or a Molina Member needs additional help or more information, call (800) 368-1019 or TTY/TDD (800) 537-7697.	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: https://www.hhs.gov/ocr/complaints/index.html

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (866) 472-4585. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

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

Documentation

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

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

Members Who Are Deaf or Hard of Hearing

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

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

Molina will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three business days in advance of an

appointment to ensure availability of the service. In most cases, Members will have made this request via Molina Member Services.

4. ENROLLMENT AND ELIGIBILITY

Enrollment in Medicaid Programs

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, such as Molina, 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.

Only Medicaid recipients who meet eligibility requirements and are living in a region Molina is authorized as a Managed Care Plan, are eligible to enroll and receive services from Molina.

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

Effective Date of Enrollment

The Agency or its agents will notify Molina of an enrollee's selection or assignment to the Plan. Enrollment in Molina shall be effective at 12:01 a.m. on the effective date of enrollment provided on the Enrollment File.

The Agency will automatically reinstate an enrollee into the Plan in which the person was most recently enrolled if the enrollee has a temporary loss of eligibility. For MMA Managed Care Plans, the "temporary loss period" is defined as no more than 180 calendar days.

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.

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:

- Secure area on the Medicaid fiscal agent's Web site (FLMMIS)
- Automated voice response that provides eligibility information using a touch-tone telephone
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response

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 assigned 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 Agency assigned 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 as noted above. 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 receive an identification card from Molina in addition to the Florida Medicaid ID card. Molina sends an identification card for each family Member covered under the plan. Members are reminded in their Member Handbooks to carry both ID cards (Molina ID card and Florida Medicaid card) with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services.

5. COVERAGE OF OUT OF NETWORK SERVICES

Out-of-Network Providers and Services

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

Out of network services are only covered as when:

- Indian Health Care Providers (IHCP), whether participating in the network or not, provide covered managed care services to Indian enrollees who are eligible to receive services from the IHCP.
- Rendering of Family planning services regardless of whether the Provider is in the Molina network.
- Rural area residents with only one MCO may seek out-of-network services from an Out-of-Network Provider under any of the following circumstances:
    - The service or type of Provider (in terms of training, experience, and specialization) is not available within the Molina network.
    - The Provider is not part of the network, but is the main source of a service to the member, provided that—
        a. The Provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO network as other network providers of that type.
        b. If the Provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the Member will be transitioned to a participating provider within 60 calendar days (after being given an opportunity to select a provider who participates).
    - The only plan or provider available to the Member does not, because of moral or religious objections, provide the service the Member seeks.
    - The Member's PCP or other Provider determines that the Member needs related services that would subject them to unnecessary risk if received separately (for

example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

Urgent Care Services

Urgent care services are covered by Molina only at Molina participating Urgent Care Centers.

Emergency Mental Health or Substance Abuse Services

Members are directed to call 911 or go to the nearest emergency room if they need Emergency Services for mental health or substance abuse. Examples of emergency mental health or substance abuse problems are:

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

Out of Area Emergencies

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

- Go to the nearest emergency room.
- Call the number on ID card.
- Call Member's PCP and follow-up within 24 to 48 hours.

For out-of-area Emergency Services, out-of-network Providers are directed to call the Molina contact number on the back of the Member's ID card for additional benefit information and may be asked to transfer Members to an in-network facility when the Member is stable.

Transition of Care for New Molina Members

Members in active treatment with a provider before becoming a member of our plan, will be able to continue to receive care from their current provider for the first 60 calendar days with our plan. After the 60 days pass, Molina will work closely with the member and the non-par provider to determine continuation of care by the non-par provider. Molina will only authorize treatment in special cases. Molina's Member Services department is able to assist members in locating a participating provider if requested.

6. HEALTHCARE SERVICES (HCS)

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results.

Prior Authorization Requirements

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes via a Look-up tool on our website. Molina prior authorization requirements are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com.

Obtaining authorization does not guarantee payment. Molina retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care. Molina does not retroactively authorize services that require PA.

All non-emergency services rendered by Non-PAR Providers will require an Authorization.

Decision Timeframes

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation. The definition of expedited/urgent is when the situation where the standard time frame or decision-making process could seriously jeopardize the life or health of the Member, the health or safety of the Member or others, due to the Member's psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determinations/pre-service authorization request, Molina will make a determination as promptly as the Member's health requires and no later than contractual requirements or two (2) calendar days after we receive the initial request for service in the

event a provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health.

For a standard authorization request, Molina makes the determination and provides notification no later than contractual requirements or seven (7) calendar days after we receive the initial request for service.

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

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 has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (855) 322-4076.

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

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five (5) business days of the decision.

A "peer" is considered a physician, physician assistant, or nurse practitioner who is directly providing care to the Member. Contracted external parties, administrators, or facility UM staff can request that a peer-to-peer telephone communication be arranged and performed.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID#
- Auth ID#
- Requesting Provider Name and contact number, best times to call

If a Medical Director is not immediately available, the call will be returned within two (2) business days. Every effort will be made to return calls as expeditiously as possible.

Requesting Prior Authorization

At times, Molina may choose to contract with external vendors to help manage prior authorization requests.

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

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

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx.

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

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

Fax: The Prior Authorization Request Form can be faxed to Molina at:

- Prior Authorizations and Admissions – (866) 440-9791
- Transplant Authorizations – (877) 813-1206
- Advanced Imaging – (877) 731-7218

7. MEDICAL RECORD REQUIREMENTS

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

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

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

Medical Records

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

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

Medical Record Keeping Practices

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

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.

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

Content

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

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

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

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each Member authorizing Molina to release medical information for facilitation of medical care.

Retrieval

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

8. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality department **toll free at** (855) 322-4076 or fax (866) 440-9791.

The address for mail requests is:

Molina Healthcare of Florida, Inc.
Quality Department
8300 NW 33rd St, Suite 400
Doral, FL 33122

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness – Special Health Care Needs
- Hypertension
- Obesity

- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

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

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include, but are not limited to:

- Adult Preventive Services Recommendations
- Recommendations for Preventive Pediatric Health Care
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

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

9. COMPLIANCE

Fraud, Waste, & Abuse

Introduction

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

Molina's Special Investigation Unit (SIU) supports compliance in its efforts to prevent, detect, and correct fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or Law enforcement agency.

Mission Statement

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented, Molina employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Molina strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, 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

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

As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation of 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

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 will take steps to monitor Molina contracted providers to ensure compliance with the law.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Molina conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKB) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKB?

AKB statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anythingofvalue" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. **Examples** of prohibited AKB actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under **Molina's policies**, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under **Molina's policies**, Marketing means any communication, to a beneficiary who is not enrolled with Molina, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Molina's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

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

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

Definitions

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

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

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to State and Federal health care programs, 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 State and Federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Molina Member for Covered Services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Molina identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider

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 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 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 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.

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

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

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

Post-payment Recovery Activities

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

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

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from

Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Provider Education

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

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

Cooperating with Special Investigation Unit Activities

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

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

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

Remember to include the following information when reporting:

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

To report suspected fraud and/or abuse in Florida Medicaid, call the **Consumer Complaint Hotline toll-free at (888) 419-3456** or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at https://apps.ahca.myflorida.com/mpi-complaintform/.

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

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

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

If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (**toll-free (866) 966-7226 or (850) 414-3990**). The reward may be up to 25 percent 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.

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

Molina expects that Providers/Practitioners will respect the privacy of Molina members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

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

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

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

1. Federal Laws and Regulations
    - HIPAA
    - The Health Information Technology for Economic and Clinical Health Act (HITECH)
    - 42 C.F.R. Part 2
    - Medicare and Medicaid laws
    - The Affordable Care Act
2. State Medical Privacy Laws and Regulations

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

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider 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'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 health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[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 to share PHI with Molina for our health care operations activities, such as HEDIS® and Quality improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

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

Written Authorizations

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

Patient Rights

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

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the member's care or payment for care.

5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.

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

HIPAA Security

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

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

HIPAA Transactions and Code Sets

Molina strongly supports the use of electronic transactions to streamline healthcare administrative activities. Providers are encouraged to submit claims and other transactions to Molina 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 is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Molina's website at http://www.molinahealthcare.com for additional information regarding HIPAA standard transactions.

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

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier

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

Reimbursement for Copies of PHI

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

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review

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

10. CLAIMS

Payer ID	51062
Availity Essentials portal	www.availity.com/molinahealthcare
Clean Claim Timely Filling	1 year after the discharge for inpatient services or the Date of Service for outpatient services

Electronic Claims Submission

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

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity Essentials portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID **51062**

Availity Essentials portal

The Availity Essentials portal is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS1500) and Institutional (CMS-1450) {UB04} Claims with attached files.
- Correct/Void Claims.
- Add attachments to Claims previously submitted Claims via Availity.
- Check Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and manage Claim Templates.
- Create and submit a Claim Appeal with attached files.

You can contact Molina at (855) 322-4076 to obtain your Molina Provider ID to facilitate registering with Availity.

Clearinghouse

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse. If you do not have a clearinghouse, Molina offers additional electronic claims submissions options as shown by logging on to the Availity Essentials portal.

Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include any and all medical records pertaining to the Claim, if requested by Molina or otherwise required by Molina's policies and procedures.

Claims must be submitted by Provider to Molina within one (1) year after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within ninety (90) days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment.

Claim Submission

Providers must follow the appropriate State and CMS Provider billing guidelines. Providers should utilize electronic billing though a clearinghouse or Molina's Availity

Essentials portal, use current HIPAA compliant ANSI X12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims).

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

To verify the status of your claims, please visit the Availity Essentials portal or call our Provider Claims Representatives at (855) 322-4076.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed thirty (30) calendar days from the change. Atypical Providers may submit their Tax ID as the primary identifier, if Provider does not have an NPI.

Required Elements

Electronic submitters should use the Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every claim, paper or electronic:

- Member name, as listed on Molina Member ID Card, date of birth and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI) or Atypical Provider Identifier (API).
- Rendering Provider information, when different than billing.
- Taxonomy of Rendering and Billing provider in alignment with Medicaid Provider Enrollment.
- Provider name and billing address.
- National Drug Code (NDC), unit of measure and quantity for medical injectables
- Place of service and/or Bill type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

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

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Electronic Corrected Claim Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called "Claim frequency codes." Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Molina will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Molina will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Paper Claim Submissions

If electronic Claim submission is not possible, all hard copy (CMS-1500, CMS-1450 {UB-04}) claims must be submitted by mail to the address listed below.

Molina Healthcare of Florida, Inc.
PO Box 22812
Long Beach, CA 90801

When submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10 or 12 point Times New Roman font, using black ink.

Link to paper Claims submission guidance from CMS:
https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

To verify the status of your claims, please visit the Availity Essentials portal or call our Provider Claims Representatives at (855) 322-4076.

Paper Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms. Molina strongly encourages Providers to submit Corrected Claims electronically via EDI or the Availity Essentials portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Corrected Claims from non-participating providers must be sent within one (1) year of Date of Service.

Corrected Claims submission options:

- Submit Corrected Claims directly to Molina via the Availity Essentials portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

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

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

COB

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina Members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary Claim processing. In the event that coordination of benefits occurs, Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Molina will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

Subrogation - Molina retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under State and Federal law and the Member's benefit plan.

If third party liability is suspected or known, please refer pertinent case information to Molina's vendor at:

- All states except KY – Optum: submitreferrals@optum.com
- KY – Conduent: tplefaxes@conduent.com

Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to Provider Services.

Reimbursement Guidance and Payment Guidelines

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

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

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

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

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

Telehealth Claims and Billing

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

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type in accordance with applicable billing guidelines.
For guidance, please refer to the resources located below:

State	Link 1	Link
FL	Telehealth Policy and General Rules	FLMedicaidFloridaMedicaid-HealthCareAlertMarch18,2020-ProviderType(s):AllMedicaidTelemedicineGuidanceforMedicalandBehavioralHealthProviders

National Correct Cording Initiative (NCCI)

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

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

service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process electronic and paper claims. Molina requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

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

Modifiers

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

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

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

ICD-10-CM/PCS Codes

Molina utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny Claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date

of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.

Molina processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

NDC

The National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, CMS-1450 (UB-04) or its electronic equivalent.

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

Claim Editing Process

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

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

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

Coding Sources

Definitions

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

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

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

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

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

Claim Auditing

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

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

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

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

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

Timely Claim Processing

Claims processing will be completed for Providers in accordance with the timeliness provisions set forth per state regulation 641.513 and the state Medicaid SMMC contract.

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

Electronic Claim Payment

Molina supports Providers, and as such would like to highlight the many benefits ERA/EFT:

- Providers get faster payment (processing can take 5-7 business days from the day the claim was submitted).
- Providers can search for a historical Explanation of Payment-EOP (aka Remittance Advice) by claim number, member name, etc.
- Providers can view, print, download and save a PDF version of the Explanation of Payment for easy reference with no paperwork to store.
- Providers can have files routed to their ftp and/or their associated clearinghouse.

There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. To register for EFT/835s, please go to the link below. Any questions during this process should be directed to ECHO Health (888) 834-3511 or edi@echohealthinc.com.

https://enrollments.echohealthinc.com/efteradirect/molinaHealthcare.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Molina standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. For members with Medicare COB Molina will provide notice within 540 days from the claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider.

If a Provider does not repay or dispute the overpaid amount within the timeframe allowed, Molina may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Refund Requests may be sent to:

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

Claim Disputes/Reconsiderations/Appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the ***Complaints and Appeals*** section of this Provider Manual.

Fraud Waste and Abuse

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

11. COMPLAINTS AND APPEALS PROCESS

Provider Complaint Process

Provider Disputes and Appeals

Molina is committed to the timely resolution of all Provider complaints. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. Provider disputes are typically disputes related to overpayment, underpayments, untimely filing, and bundling issues. Provider Appeals are requests related to a denial of an authorization or medical criteria.

Providers disputing a Claim previously adjudicated must request such action within one year of Molina's original remittance advice date. A written acknowledgement letter will be mailed within three business days of receipt of a claim dispute or appeal. In addition, a written notice of the status of your request will be mailed every 30 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within 60 days of receipt of the claim dispute or appeal.

Molina has a dedicated staff for Providers available to receive and resolve claim dispute and appeals. Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Florida via the Availity Essentials portal. https://www.availity.com/molinahealthcare.
- Submit requests directly to Molina Healthcare of Florida via fax at: (877) 553-6504
- Submit Provider Appeal request to MFL_ProviderAppeals@MolinaHealthcare.com
- Submit Provider Disputes through Provider Services at (855) 322-4076 (Monday – Friday, 8am – 5pm)
- Submit requests via mail to:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030

Pleasenote:

- Claims denied for missing documentations such as consent forms, explanation of benefits from primary carrier, or itemized bills are not disputes. These must be submitted as a new claim with the required attachments to Molina. They can either be submitted electronically or mailed (claim form with supporting documents requested) to:

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

- Requests for adjustments of claims paid by a delegated Subcontract must be submitted to the group responsible for payment of the original claim. Please refer to the ***Subcontractor Complaints Information*** section of this Billing guide for contacts.

Maximus

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

Maximus Federal Services State Appeals Process
50 Square Drive
Suite 120
Victor, NY 14564

Tel: (866) 763-6395
Fax: (585) 425-5296

Provider Complaints Not Related to Claims

Providers with complaints not related to claims have 45 days to file a complaint. A written acknowledgement letter will be mailed within three business days of receipt of complaint. In addition, a written notice of the status of your request will be mailed every 30 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within 90 days of receipt and provided written notice of the disposition and the basis of the resolution within three business days of resolution.

To file a Provider Complaint not related to claims, Providers may contact Provider Services at (855) 322-4076, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida
Appeal and Grievance Unit
P.O Box 36030
Louisville, KY 40233-6030

Provider Dispute/Appeal Form

Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all disputes should be submitted on the Molina Provider Dispute/Appeal Form found on Provider website and the Availity Essentials portal to help ensure all necessary information to timely and appropriately process the dispute is provided.

Subcontractor Complaints Information

Subcontractor Provider Complaints Information	
Transportation	**Access2Care** • Mailing Address: Access2Care,16331 Bay Vista Drive, Clearwater, FL 33760 • Contact Number: (844) 814-4092 • Fax Number: (888) 305-8246 • Email: SRTSouth@amr.net
Therapy	**Health Network One** • Mailing Address: Health Network One, Inc., P.O. Box 350590, Fort Lauderdale, FL 33335-0590 • Contact Number: (888) 550-8800 • Fax Number: (305) 620-5973 • Email: ATAFL@healthnetworkone.com
DME, Home Health, Home Infusion (For MMA and Specialty Plan)	**CoastalCare** • Mailing Address: Coastal Care Solutions, 7875 NW 12 ST, Suite 200, Miami, FL • 33126 • Contact Number: (855) 481-0505 • Website: www.ccsi.care
Vision	**iCareSolutions** • Mailing Address: iCare Provider Relations; 5440 Mariner Street, Suite 112, Tampa, FL 33609 • Contact Number (855) 373-7627 • Email: grievances@myicarehealth.com • Website: ehealthdeck.com/

12. JOINING THE MOLINA NETWORK

Providers who are interested in joining the Molina can reach out to our team at MFLProviderNetworkManagement@MolinaHealthCare.Com or submit a "Provider Contract Request Form" available online on our provider website at: https://www.molinahealthcare.com/providers/fl/medicaid/forms/fuf.aspx.

Once Molina has received your request, one of our Provider Contracting Managers will reach out to you to complete the next steps. Please note, in accordance with federal and state requirements, Molina requires an active Medicaid ID for both the Provider and the group either as "Fully Enrolled" or "Limited Enrolled".

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

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

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

Non-Discriminatory Credentialing and Recredentialing

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

Types of Practitioners Credentialed & Recredentialed

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

Practitioner types requiring credentialing include but are not limited to:

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

Credentialing Turn Around Time

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

Criteria for Participation in the Molina Network

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

Molina reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Molina may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Molina and the community it serves. The refusal of Molina to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. The Practitioner shall have the burden of producing adequate information to prove they meets all criteria for initial participation and continued participation in the Molina network. If the Practitioner fails provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Provider must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** – Provider must hold a current and valid license, certification, or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are

required to be licensed in the State where they are located and the State the member is located.

- **DEA or CDS Certificate** – Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty** – Provider must only be credentialed in the specialty in which they have adequate education and training. Provider must confine their practice to their credentialed area of practice when providing services to Molina Members.
- **Education** –Provider must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training** – Provider must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.
- **Fellowship Training** – If the Provider is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)

- American Osteopathic Association (AOA)
- American Board of Foot and Ankle Surgery (ABFAS)
- American Board of Podiatric Medicine (ABPM)
- American Board of Oral and Maxillofacial Surgery
- American Board of Addiction Medicine (ABAM)
- College of Family Physicians of Canada (CFPC)
- Royal College of Physicians and Surgeons of Canada (RCPSC)
- Behavioral Analyst Certification Board (BACB)
- National Commission on Certification of Physician Assistants (NCCPA)

- **General Practitioners** – Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or Wound Care. General Practitioners providing only wound care services do not require five years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Molina may credential a Practitioner who is not licensed to practice independently. In these instances, it would also be required that the Practitioner providing the supervision and/or oversight be contracted and credentialed with Molina.
- **Work History** – Provider must supply most recent five years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.
- **Malpractice History** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative

response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Molina will also verify all licenses, certifications, and registrations in every State where the Practitioner has practiced. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner must not be currently sanctioned, excluded, expelled, or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any criminal convictions. Practitioners must never have been convicted, including guilty pleas and adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes. Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes. Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct. Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act. Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of healthcare, patient abuse or neglect, controlled substances, or similar crimes. At the time of initial credentialing, practitioner must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is

required from the Practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.

- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioner must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).

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

Molina will notify the Practitioner immediately in writing in the event credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification, sanctions, or exclusions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Molina website and are included in this Provider Handbook.

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

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

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made

immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing Department will notify the Practitioner.

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

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

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Molina website and are included in this Provider Handbook.

The Practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Practitioner are documents, which the Practitioner sent to Molina (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have a right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner's rights are published on the Molina website and are included in this Provider Handbook. Molina will respond to the request within two working days. Molina will share with the Practitioner where the application is in the credentialing process and note any missing information or information not yet verified.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals are not required.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager, or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the

Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality are identified. If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare and Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** – Molina enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Providers sanctioned with SAM.

13. 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.

AHCA – Agency for Health Care Administration

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 a designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

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.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04 (CMS-1450), or successor, submitted electronically.

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

Complaint – Any written or oral expression of dissatisfaction.

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

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

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

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

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

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. Claims submitted by Providers are converted to encounters and submitted to AHCA as required by contract.

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

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

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.

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

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

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

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

Medically Necessary Services – FS 409.9131 (2) (b) Any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

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

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

Member – A current or previous Member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

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

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

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 Molina 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, or Obstetrician/Gynecologists as designated by Molina Healthcare.

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

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

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

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

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

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

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

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

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

Telemedicine — The practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

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

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

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

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

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

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

prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Well Child Visit (formerly known as CHCUP) – Early Periodic Screening Diagnosis and Treatment Program

**********END OF BILILNG GUIDE**********