Molina Healthcare of Ohio
2026 MyCare Ohio Provider Manual: Addendum – Dec. 2025

Section Title: VIII. Claims Information

Subsection Title:

The following language will be updated:

Current Language

VIII. Claims Information

Molina generally follows CMS billing guidelines for Medicare Covered Services and ODM guidelines for non-Medicare Covered Services for the Molina Complete Care for MyCare Ohio plan. Providers will have 365 days to timely file a Claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) Rule 5160-1-19.

Availity Essentials Portal	availity.com/providers/
Clean Claim Timely Filling: MyCare Ohio Medicaid	Unless otherwise agreed upon by ODM, Molina shall accept claims from all provider types for up to 365 calendar days from the date of service.
Clean Claim Timely Filing: Molina Complete Care for MyCare Ohio	• For services that bypass Medicare and Molina processes as the primary payer (MyCare Ohio Medicaid) timely filing limit is up to 365 calendar days from the date of service. • When Molina Complete Care for MyCare Ohio processes as the primary payer, the timely filing limit is up to 365 days from the date of service. • Out-of-network: 365 days from the date of service.

New Language: Underlined below

VIII. Claims Information

Molina generally follows CMS billing guidelines for Medicare Covered Services and ODM guidelines for non-Medicare Covered Services for the Molina Complete Care for MyCare Ohio plan. Providers will have 365 days to timely file

a Claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) Rule 5160-1-19.

Availity Essentials Portal	availity.com/providers/
Clean Claim Timely Filling: MyCare Ohio Medicaid	For services that bypass Medicare and Molina processes as the primary payer (Molina MyCare Ohio Medicaid) the timely filing is 365 calendar days.
Clean Claim Timely Filing: Molina Complete Care for MyCare Ohio	When Medicare and/or Molina Complete Care for MyCare Ohio is processed as the primary payer, the timely filing limit is based on the Provider's contract language (standard is 120 days).
Out-of-Network	365 days from the date of service.

Section Title: VIII. Claims Information

Subsection Title: B. Timely Claim Filing Requirements

The following language will be updated:

Current Language

B. Timely Filing Requirements

Providers will have 365 days to timely file a Claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) Rule 5160-1-19.

Timely Claim Filing

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

If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 90 calendar days after the 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 and the Provider hereby waives any right to payment.

Original Claims: Claims for Covered Services rendered to Molina Complete Care for MyCare Ohio Medicare-Medicaid Members must be received by Molina no later than the filing limitation stated in the Provider contract or within 365 days from the date of service(s) for MyCare Ohio. Claims submitted after the filing limit will be denied.

New Language: Underlined below

B. Timely Filing Requirements

Providers will have 365 days to timely file a Claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) Rule 5160-1-19:

Clean Claim Timely Filling: MyCare Ohio Medicaid	For services that bypass Medicare and Molina processes as the primary payer (Molina MyCare Ohio Medicaid) the timely filing is 365 calendar days.
Clean Claim Timely Filing: Molina Complete Care for MyCare Ohio	When Medicare and/or Molina Complete Care for MyCare Ohio is processed as the primary payer, the timely filing limit is based on the Provider's contract language (standard is 120 days).
Out-of-Network	365 days from the date of service.

Timely Claim Filing

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

If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 90 calendar days after the 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 and the Provider hereby waives any right to payment.

Original Claims: Claims for Covered Services rendered to:

- Molina MyCare Ohio Medicaid: For services that bypass Medicare and Molina processes as the primary payer, the timely filing is 365 calendar days.
- Molina Complete Care for MyCare Ohio: When Medicare and/or Molina Complete Care for MyCare Ohio is processed as the primary payer, the timely filing limit is based on the provider's contract language (standard is 120 days).

Provider Manual

(Provider Handbook)

Molina Healthcare of Ohio, Inc.

(Molina Healthcare or Molina)

Molina MyCare Ohio

2026

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" have the same meaning as "Health Plan" in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com/OhioProviders.

Last Updated: 11/2025

MOLINA® HEALTHCARE

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I. Welcome and Introduction

Thank you for your participation in delivering quality health care services to Molina Healthcare (Molina) Members. We look forward to working with you.

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein to the Molina Healthcare of Ohio, Inc. Services Agreement.

The information contained within this manual is proprietary. The information is not to be copied in whole or in part. Nor is the information to be distributed without the express written consent of Molina.

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

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through its locally operated health plans, Molina serves approximately 5 million Members.

Molina contracts with state governments and serves as a health plan, providing a wide range of quality health care services to families and individuals who qualify for government-sponsored programs, including Medicaid and the State Children's Health Insurance Program (SCHIP).

II. Basic Plan Information

A. General Contact Information

Molina Healthcare of Ohio
3000 Corporate Exchange Drive
Columbus, Ohio 43231

Provider Services Department

The Provider Services Department handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility and general concerns.

- Availity Essentials portal: availity.com/providers/
- Phone: (855) 322-4079 (8 a.m. to 8 p.m., Monday through Friday)

Providers must submit Claims electronically via the Ohio Department of Medicaid Ohio Medicaid Enterprise System (OMES) through EDI or direct data entry claims via the Availity Essentials portal.

EDI Payer ID Number: Molina's payer IDs for all lines of business, including the Next Generation MyCare Ohio OMES EDI transactions for dates of service before, on and after Jan. 1, 2026, are noted in the chart below.

For the Legacy MyCare Ohio Plan and the Next Generation MyCare Ohio Plan, providers must submit claims utilizing the Payer ID 0021586 for all dates of service submitted on Jan. 1, 2026 and after.

EDI Payer IDs		
Line of Business	**Payer ID**	**Which Member ID do I bill with?**
Ohio ABD (Medicaid)	0007316	Molina's Medicaid Member ID
Ohio Adult Extension (Medicaid)	0007316	Molina's Medicaid Member ID
Ohio Healthy Families (Medicaid)	0007316	Molina's Medicaid Member ID
SKYGEN Dental: Medicaid	D007316	Molina's Medicaid Member ID
March Vision: Medicaid	V007316	Molina's Medicaid Member ID
Ohio Marketplace Program	20149	Molina's Marketplace Member ID
Ohio Marketplace Program Primary with Ohio Medicaid Secondary (ABD, Adult Extension, Healthy Families)	20149	Molina's Marketplace Member ID
New Plan: Molina Complete Care for MyCare Ohio (HMO D-SNP/FIDE) (Dual Benefits) **for dates of service 1/1/2026 and after.**	0021586	Molina's Medicaid Member ID
New Plan: Molina MyCare Ohio Medicaid (Medicaid Only) **for dates of service 1/1/2026 and after.**	0021586	Molina's Medicaid Member ID

EDI Payer IDs		
Line of Business	**Payer ID**	**Which Member ID do I bill with?**
Legacy Plan: Molina Dual Options MyCare Ohio (HMO D-SNP) (Opt In) **for dates of service 12/31/2025 and prior.**	0021586	Molina's Medicaid Member ID
Legacy Plan: Molina MyCare Ohio Medicaid (Opt Out) **for dates of service 12/31/2025 and prior.**	0021586	Molina's Medicaid Member ID
SKYGEN Dental: Molina Complete Care for MyCare Ohio (HMO D-SNP/FIDE) (Dual Benefits)	D0021586	Molina's Medicaid Member ID
SKYGEN Dental: Molina MyCare Ohio Medicaid (Medicaid Only)	D0021586	Molina's Medicaid Member ID
March Vision: Molina Complete Care for MyCare Ohio (HMO D-SNP/FIDE) (Dual Benefits)	V0021586	Molina's Medicaid Member ID
March Vision: Molina MyCare Ohio Medicaid (Medicaid Only)	V0021586	Molina's Medicaid Member ID
Molina Medicare DSNP (Medicare/MAPD)	20149	Molina's Medicare Member ID

To verify the status of your Claims please use the Availity Essentials portal. Claims questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity Essentials portal, or by contacting the Provider Contact Center.

Eligibility verifications can be conducted at your convenience via the Eligibility and Benefits module on the Availity Essentials portal.

Provider Relations Department

In addition to the Provider Services Call Center, Molina has Ohio-based Provider Relations Representatives who serve all of Molina's Provider network.

The Provider Relations Department handles written inquiries from Providers regarding education, training and escalated issues.

Molina has designated email addresses based on provider types to help get your questions answered more efficiently or to connect you to training opportunities. Refer to the Provider Representatives information below for more details.

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints, offer to assist Members with obtaining covered services and resolving grievances, including requesting authorization of services, and navigating Medicaid appeals and grievances regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid managed care plan. Member Services Representatives are available Monday through Friday from 8 a.m. to 8 p.m. for Molina Complete Care for MyCare Ohio, excluding holidays and the Day after Thanksgiving.

Phone:

- Molina Complete Care for MyCare Ohio: (855) 665-4623
- Molina MyCare Ohio Medicaid: (855) 687-7862
- TTY/TDD: 711

Claims Department

Providers must submit Claims electronically via the Ohio Department of Medicaid Ohio Medicaid Enterprise System (OMES) through EDI or direct data entry claims via the Availity Essentials portal.

To verify the status of your Claims, please use the Availity Essentials portal. Claims questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity Essentials portal or by contacting Provider Services. Access the Availity Essentials portal at availity.com/providers/.

Claims Recovery Department

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

Provider Disputes:
Molina Healthcare of Ohio

PO Box 2470
Spokane, WA 99210-2470

Providers may also file an overpayment Dispute through the Availity Essentials portal.

Refund Checks Lockbox:
Molina Healthcare of Ohio
PO Box 78000 Dept. 781661
Detroit, MI 48278-1661

Phone: (866) 642-8999
Fax: (888) 396-1517

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina AlertLine or submitting an electronic complaint using the website listed below. For information on fraud, waste, and abuse, please refer to the Compliance section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare of Ohio Medicare
Attn: Compliance Official
200 Oceangate Suite 100
Long Beach, CA 90802

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

Credentialing Department

Please direct any credentialing inquiries to the Ohio Department of Medicaid (ODM) at Credentialing@medicaid.ohio.gov or visit the website: managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.

24- Hour Nurse Advice Line

This telephone-based Nurse Advice and Behavioral Health Crisis Line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, 365 days a year.

Phone: (855) 895-9986
TTY/TDD: 711

Health Care Services

The Health Care Services (formerly Utilization Management) Department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The Health Care Services (HCS) Department also performs Care Coordination for Members who will benefit from Care Coordination services. Participating Providers are required to interact with Molina's HCS Department electronically whenever possible. Prior Authorizations/Service Requests and status checks can be easily managed electronically.

Availity Essentials portal: Molina is transitioning to a portal-only submission model for Prior Authorization. Managing Prior Authorizations/Service Requests electronically via the ODM OMES system for EDI transactions or via the Availity Essentials portal for direct data entry provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks.
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces costs associated with fax and telephonic interactions.

Availity Essentials portal: availity.com/providers/
Phone: (855) 322-4079
View the PA Request Form and Instructions

Behavioral Health

Molina manages all components of Covered Services for behavioral health. For Member behavioral health needs, please contact us directly at (855) 322-4079. Molina has a Behavioral Health Crisis Line that Members may access 24 hours per day, 365 days per year, by calling the Member Services number on the back of their Molina ID card.

Pharmacy Department

Providers are required to adhere to ODM's Unified Preferred Drug List and Molina's prescription policies. The Unified Preferred Drug List is available on the Drug Formulary page of our Provider Website.

A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina.

Phone: (800) 665-3086
Part D Fax: (866) 290-1309
J Code Fax: (800) 391-6437

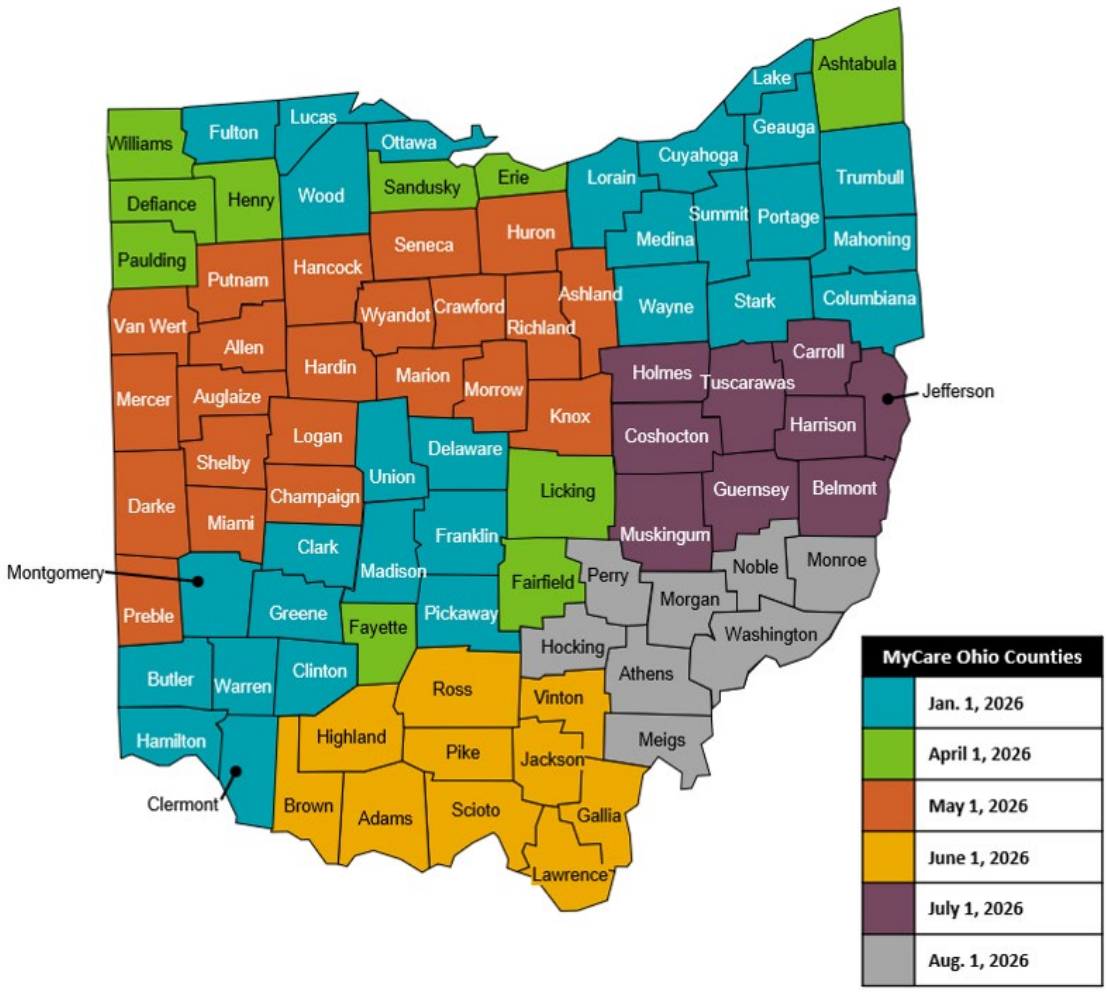
Quality Improvement

Molina maintains a Quality Improvement (QI) Department to work with Members and Providers in administering the Molina Quality Program.

Phone: (855) 322-4079

Molina Healthcare of Ohio, Inc. Service Area

MyCare Ohio counties with effective dates.



B. Provider Call Center

Provider Services is available at (855) 322-4079, TTY 711, during the hours of 8 a.m. to 8 p.m. Eastern, Monday through Friday, except for the following major holidays:

- Memorial Day Holiday

- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

A holiday that falls on a Saturday is observed on the Friday before the holiday. A holiday that falls on a Sunday is observed on the Monday after the holiday.

Provider Services Call Center staff will be available from 8 a.m. to 8 p.m. Christmas Eve Day, New Year's Eve Day, New Year's Day, Martin Luther King Jr. Day and President's Day.

C. Provider Representative Information

The Provider Relations Department handles written inquiries from Providers regarding education, training and escalated issues. In addition, the Availity Essentials portal offers many self-service capabilities for Providers' convenience.

In addition to the Provider Services Call Center, Molina has Ohio-based Provider Relations Representatives who serve all of Molina's Provider network.

Molina has designated email addresses based on Provider types to help get your questions answered more efficiently or to connect you to training opportunities.

Behavioral Health questions:
BHProviderRelations@MolinaHealthcare.com

Hospital or hospital-affiliated physician group questions:
OHProviderRelationsHospital@MolinaHealthcare.com

Home Health Agencies and Independent Providers, Waiver (LTSS), Laboratories, Ancillary Dialysis Centers, Transportation and Durable Medical Equipment questions:
OHMyCareLTSS@MolinaHealthcare.com

Skilled Nursing, Long Term Care, Hospice and Assisted Living Facilities questions:
OHProviderRelationsNF@MolinaHealthcare.com

Physician and Specialist questions:
OHProviderRelationsPhysician@MolinaHealthcare.com

General questions:
OHProviderRelations@MolinaHealthcare.com

Phone: (855) 322-4079 (8 a.m. to 8 p.m. EST, Monday through Friday)

Fax: (888) 296-7851

III. Provider Resources

A. Provider Services (Call Center) Information

Provider Services is available at (855) 322-4079, TTY 711, during the hours of 8 a.m. to 8 p.m. Eastern, Monday through Friday, except for the following major holidays:

- New Year's Day
- Martin Luther King Jr. Holiday
- Memorial Day Holiday
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve Day – Open 7 a.m. until Noon
- Christmas Day
- New Year's Eve Day – Open 7 a.m. until Noon

A holiday that falls on a Saturday is observed on the Friday before the holiday. A holiday that falls on a Sunday is observed on the Monday after the holiday.

B. Provider Portal: Availity Essentials Portal

Access the Availity Essentials portal at (availity.com/providers/).

All MyCare Ohio direct data entry Prior Authorization and Claim submissions must be submitted via the Availity Essentials portal. Claim submissions via EDI must be directed through the ODM OMES system.

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

- Verify Member eligibility and covered services
- View Healthcare Effectiveness Data and Information Set (HEDIS®) data, identify gaps or missed services with care reminders
- Identify Member's primary language and special communication needs
- Claims:
  - Submit Professional (CMS-1500) and Institutional (UB-04) Claims with attached files
  - Correct/Void Claims
  - Add attachments to open or pending submitted Claims
  - Check Claims status

  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage Claim templates
  - Submit and manage Claim disputes, including formal appeals or reconsideration requests, for finalized Claims
  - View, dispute, resolve Claim overpayments
  - Track status of Claim Appeals
- Prior Authorizations/Service Requests:
  - Create and submit Prior Authorization/Service Requests
  - Check the status of Authorization/Service Requests
- Connect with Molina agents via secure messaging to resolve eligibility, benefit and claim inquiries
- Run and retrieve/download claim reports
- Access resources such as Provider Forms, Culturally and Linguistically Appropriate Services Training, Provider Manual and Training, and more

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

C. Provider Policies

Molina posts and maintains Provider policies on our Provider Website under the Policies tab. Any material changes to the published policies are communicated in the Molina Provider Bulletin with advance notice prior to implementation. Please visit the Provider Website for the complete list of policies.

Molina posts our Molina Clinical Policies and Molina Clinical Reviews (MCRs) at MolinaClinicalPolicy.com. These policies are used by Providers as well as Molina's Medical Directors and internal reviewers to make Medical Necessity determinations.

Providers may also access the Medicaid policies by visiting the website above and clicking the Ohio Medicaid button at the bottom of the page or directly accessing the Ohio Medicaid Policy page through this link: Molina Ohio Clinical Policy.

D. Listserv Subscriptions

Molina does not have a Listserv available to Providers.

E. Claims Payment Systemic Error (CPSE) Report

A claims payment systemic error (CPSE) is defined as Molina's Claims adjudication incorrectly underpaying, overpaying, or denying Claims that impact five or more Providers. A report containing all active CPSEs is updated monthly and can be found here: Claims Payment Systemic Errors.

F. Forms

All published Molina Provider forms are available on the "Forms" page of our Provider Website. Also, see the links to key forms below:

- Link to ODM Forms Page links to required ODM forms. Below are descriptive titles for frequently used ODM and Molina forms.
- Consent Form
  - Consent for Hysterectomy Form
  - Abortion Certification Form
  - Consent for Sterilization Form
    - Guidelines for Completing Consent to Sterilization Form
  - Standard Authorization Form
    - Guidelines for Completing the Standard Authorization Form
- Next Generation Program Standardized Appeal Form
- Provider-Specific Appeal Forms
  - Request for Claim Reconsideration Form (Non-Clinical Claim Dispute Form)
  - Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form)
- SUD Residential Admission Form
- Medicaid Addendum
- Out-of-Network Provider Application
- Medicaid MyCare Ohio Provider Agreement
- Prior Authorization

G. Provider Trainings

Molina Provider Relations regularly engages Providers with pre-scheduled monthly training opportunities that consist of the following:

- Provider Orientations
- General, Provider type or topic-specific training
- Monthly You Matter to Molina (YMTM) Provider Forum series
- Additional training sessions are available upon Provider request if the scheduled training options are not convenient

Note: Molina also posts Culturally and Linguistically Appropriate Services training content and videos on the Availity Essentials portal.

Molina welcomes Provider feedback on training sessions and future training topics. Upon request, Molina will develop personalized content for Providers who have specific training needs. For the most current schedule of upcoming training opportunities and call-in information, please reference the training calendar posted on the Provider Website on the You Matter to Molina page or consult the Provider Bulletin.

Molina also offers training sessions and materials as directed by ODM to both in- and out-of-network Providers, and delegated subcontractors on the below topics. Training information is also available on the Provider Website and includes a link to access trainings directly via ODM's website at managedcare.medicaid.ohio.gov/providers/provider-webinars-training:

- The ODM Provider Network Management (PNM) system Prior Authorization and Claims submission requirements and billing guidance/instructions for Providers submitting Claims.

Molina may request Providers' and delegate subcontractors' attestations that they have received Molina-provided training on applicable program requirements and Molina operational requirements. Providers are also required to attend ODM-delivered Provider trainings, as mandated by ODM.

Find reference materials and registration information on ODM-provided trainings at managedcare.medicaid.ohio.gov/providers.

H. Provider Advisory Council

Molina will host at least three Provider Advisory Council (PAC) meetings per year. The purpose of the PAC is for Molina to gather input, learn about issues affecting Providers, solicit new value-based payment initiative/implementation ideas, identify challenges and barriers, problem-solve, share information; and collectively find ways to improve and strengthen the health care service delivery system, such as through consultation and adoption of clinical best practice guidelines.

Molina will invite all network Providers to self-select for participation, in addition to directly recruiting Providers to help ensure the group is composed of a wide array of Provider types, including dental and behavioral health Providers. Providers are invited to attend via phone or Microsoft Teams, and some PAC meetings may offer an in-person option.

If you are interested in joining the Provider Advisory Council, contact Molina Provider Relations at OHProviderRelations@MolinaHealthcare.com.

IV. Provider Responsibilities

A. Maintenance

The Ohio Medicaid provider network management (PNM) system serves as the system of record for provider data for ODM and Molina. As a result, data in the PNM system is used in claims payment, the Molina provider directory, and ODM provider directory. To ensure provider information remains current, it is important for providers to keep their information up to date in the PNM system. Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible for notifying ODM of changes within 30 days (see OAC 5160-1-17.2 (F)).

Updating the PNM system:

- When there is a change in a provider's information, providers must log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self-service functions include, but are not limited to:
  - location changes,
  - specialty changes, and
  - key demographic (e.g., name, NPI, etc.) changes.
- Once information is accepted into the PNM system, accepted information is sent to the MCOPs daily for use in their individual directories. The provider must update their information in the PNM system first before the MCOPs are able to make changes to their directory. MCOPs are required to direct providers back to the PNM system if there are changes.
- Not all changes happen automatically. Some self-service updates/changes require ODM staff review and approval before they are saved to the provider's record. Providers should validate if a change has been accepted/ updated in PNM before expecting it to show up for the MCOP. For a list of updates that are automatic versus manual, please see the Updating a Provider File Quick Reference Guide.

Molina may require additional information not available in the PNM system. This information will be requested during the contracting process and should be updated as changes occur, including PCP capacity/PCP directory flag, Tax ID changes, telehealth availability, accepting new members and/or a Molina directory flag. Please refer to the IV. Provider Responsibilities, E. Molina Provider Responsibilities, Provider Data Accuracy and Validation section of this Provider Manual.

Telephone surveys may be randomly conducted to Provider offices to verify the information published in Molina's directories. Please ensure all staff answering telephone calls are knowledgeable of the practitioners working at a practice and their participation status with Molina. In the event inaccurate information is provided during telephone surveys, Molina will follow-up with the office to ensure re-education of practice staff and verification of current Provider data. Repeated communication of inaccurate information may result in a corrective action plan issued to the practice as it is critical that Members may access needed healthcare services from Molina's network of Providers.

B. HIPAA and PHI

HIPAA (Health Insurance Portability and Accountability Act) Requirements and Information

Molina's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina 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).

To view our Notice of Privacy Practices for our Members, please visit our Member website at MolinaHealthcare.com/Members and select "HIPAA Privacy Notice" at the bottom of the page.

Provider Responsibilities

Molina expects that its contracted Providers will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI.

Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses PHI and includes a summary of how Molina safeguards PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

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

Applicable Laws

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

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

2. State Medical Privacy Laws and Regulations
   Providers should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in 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.

Artificial intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician. In addition, the Provider shall not use AI-generated voice technology, including but not limited to AI voice bots, voice cloning or synthetic speech systems to initiate or conduct outbound communications to Molina. The prohibition includes, but is not limited to, communications for billing, eligibility verification, prior authorization or any other administrative function.

Notwithstanding the foregoing, the Provider shall give advance written notice to your Molina Contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to Molina Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by Molina, the Provider further agrees to (i) allow Molina to audit Providers' AI use, as requested by Molina from time to time, and (ii) to cooperate with Molina with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to Molina Members.

If you have additional questions, please contact your Molina Contract Manager.

Use and Disclosure 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 health care 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,

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

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
   - Care 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 under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention or treatment. "SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, 42 CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to Molina with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, specifically Sections 2.31 and 2.32, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided.

Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform Molina that they are a Part 2 Program.

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

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

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

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

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

3. **Requests for Confidential Communications**
   Patients may request that a health care 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 health care operations.

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 – both financial and medical – is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

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

HIPAA Transactions and Code Sets

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

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

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

1. Click on the area titled "Health Care Professionals"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transaction" or "HIPAA Code Sets"

Code Sets

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

National Provider Identifier (NPI)

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

Categories of Permitted Uses & Disclosures of PHI

- **Treatment (T):**
  - Referrals
  - Provision of care by Providers
- **Payment (P):**
  1. Eligibility verification
  2. Enrollment/disenrollment

3. Claims processing and payment
4. Coordination of benefits
5. Subrogation
6. Third party liability
7. Encounter data
8. Member utilization management (UM)/Claims correspondence
9. Capitation payment and processing
10. Collection of premiums or reimbursements
11. Drug rebates
12. Reinsurance Claims
13. UM:
    - Pre-authorizations
    - Concurrent reviews
    - Retrospective reviews
    - Medical Necessity reviews

- **Health Care Operations (HCO):**
  1. Quality assessment and improvement:
     - Member satisfaction surveys
     - Populated based Quality Improvement (QI) studies
     - HEDIS® measures
     - Development of clinical guidelines
     - Health improvement activities
     - Care management contacting Providers and Members about treatment alternatives
     - Disease management
  2. Credentialing and accreditation:
     - Licensing
     - Provider credentialing
     - Accreditation (e.g., NCQA)
     - Evaluating Provider or practitioner performance
  3. Underwriting or contract renewal
  4. Auditing – conducting or arranging for:
     - Auditing
     - Compliance
     - Legal
     - Fraud and abuse detection
     - Medical review
  5. Business planning and development:
     - Cost management
     - Budgeting
     - Formulary development
     - Mergers and acquisitions, including due diligence

6. Business management and general administrative activities:
    - Member Services, including complaints and grievances, and Member materials fulfillment
    - De-identification of data
    - Records and document management (if the documents contain PHI)

Other Permitted Uses and Disclosures (OP):

1. Public Health:
    - Reporting to immunization registries
    - Reporting of disease and vital events
    - Reporting of child abuse or neglect
    - Report adverse events for FDA-regulated products
    - Victims of abuse, neglect or domestic violence (except for child abuse) to regulators (e.g., Ohio Department of Insurance) for Health Care Oversite, including audits, civil and criminal investigations
2. Judicial and administrative proceedings:
    - Court orders
    - Subpoenas and discovery requests (without court order)
    - Workers' compensation
3. Disclosures for law enforcement:
    - Court ordered warrants and summons
    - Grand jury subpoenas
    - Identification and location purposes
4. Information about decedents:
    - To coroners and medical examiners
    - To funeral directors
    - Organ donation
5. Research (e.g., clinical trials)
6. Special government functions:
    - Military activities
    - National security
    - Protective services for President

Cybersecurity Requirements

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by Molina to perform a health plan function(s), and in connection with such delegated functions.

1. Definitions:
    (a) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider

or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

(b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition, or other breach of confidentiality, data integrity or security compromise of a network or server resulting in the known or reasonably suspected accidental, unauthorized, or unlawful destruction, loss, alteration, use, disclosure of, or access to Molina Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition, or disclosure of Molina Information, or sustained interruption of service obligations to Molina.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1, or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:

i. Molina's proprietary and/or confidential information;

ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon, and Molina Information that are accessible to, or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

(a) Policies, Procedures, and Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, including as applicable, a written information security program, which Molina shall be permitted to audit via written request, and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and Molina Information accessible to or held by Provider.

ii. Encryption. Use of encryption to protect Molina Information, in transit and at rest, accessible to or held by Provider.

iii. Security. Safeguarding the security of the Information Systems and Molina Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.
ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).
iii. Data Storage. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.
iv. Data Encryption. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").
v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.
vi. Data Re-Use. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider's Agreement with Molina and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade, or disrupt Provider's delivery of services to Molina.
   (a) Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b) BC/DR Plan.
   i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:
      a) Notification, escalation and declaration procedures.
      b) Roles, responsibilities and contact lists.
      c) All Information Systems that support services provided to Molina.
      d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina.
      e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
      f) Detailed list of resources to recover services to Molina including but not limited to: applications, systems, vital records, locations, personnel, vendors, and other dependencies.
      g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.
      h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.
   ii. To the extent that Molina Information is held by Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.
   iii. Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed twenty-four (24) hours, of either of the following:
   i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.
   ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider

shall provide Molina a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.
   (a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.
   (b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than twenty-four (24) hours from Provider's discovery of the Cybersecurity Event.
      i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within twenty-four (24) hours following such payment.
      ii. Within fifteen (15) days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.
   (c) Notification to Molina's Chief Information Security Officer shall be provided to:
      Molina Chief Information Security Officer
      Telephone: (844) 821-1942
      Email: CyberIncidentReporting@Molinahealthcare.com
      Molina Chief Information Security Officer
      Molina Healthcare, Inc.
      200 Oceangate Blvd., Suite 100
      Long Beach, CA 90802
   (d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a

Cybersecurity Event involving Molina Information without the prior written consent of Molina

(e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation, or, upon request by Molina, complete an investigation pursuant to the following requirements:
   i. make a determination as to whether a Cybersecurity Event occurred;
   ii. assess the nature and scope of the Cybersecurity Event;
   iii. identify Molina 's Information that may have been involved in the Cybersecurity Event; and
   iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Molina Information.

(f) Provider must provide Molina the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following, to the extent known:
   i. the date of the Cybersecurity Event;
   ii. a description of how the information was exposed, lost, stolen, or breached;
   iii. how the Cybersecurity Event was discovered;
   iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;
   v. the identity of the source of the Cybersecurity Event;
   vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
   vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
   viii. the period during which the Information System was compromised by the Cybersecurity Event;
   ix. the number of total consumers in each State affected by the Cybersecurity Event;
   x. the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
   xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
   xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and

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

(g) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Molina's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider's Agreement with Molina will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider's Agreement with Molina.
6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider, but are not contained in this section.
7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

C. Provider Obligations for Oral Translation, Oral Interpretation and Sign Language Services

Integrated Quality Improvement

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

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

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

Members with Limited English Proficiency (LEP), Limited Reading Proficiency (LRP), or Limited Hearing or Sight

Molina is dedicated to serving the needs of our Members and has made arrangements to ensure that all Members have information about their health care provided to them in a manner they can understand.

All Molina Providers are required to comply with OAC Rule 5160-26-05.1 and Title VI of the Civil Rights Act of 1964 in the provision of Covered Services to Members. Compliance with this provision includes providing interpretation and translation services for Members requiring such services, including Members with LEP. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Documentation of such services shall be kept in the Member's chart.

Access to Language Services

Molina 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.

All eligible Members who are Limited English Proficient (LEP) are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP) or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are Molina Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services. Molina is available to assist Providers with locating these services if needed.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

Molina Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, and the Civil Rights Act of 1964.

- Be given access to Care Coordinators trained to work with cognitively impaired individuals.
- Be notified by the medical Provider that interpreter services, including ASL are available at no cost.
- Be given reasonable accommodations, appropriate auxiliary aids and services
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation.
- Be assured of confidentiality, as follows:
  - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records.
  - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf.
  - Interpreters must ensure that this shared information is similarly safeguarded.
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan.
- Interpreters include people who can speak the Member's primary language, assist with a disability or help the Member understand the information.

When Molina Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
  - Providers needing assistance finding onsite, video remote or telephonic interpreter services may call Molina Member Services.
  - Providers needing assistance obtaining written materials in preferred languages.
  - Providers with Members who cannot hear or have limited hearing ability may use the Ohio Relay service (TTY) at 711.
  - Providers with Members with limited vision may contact Molina Member Services for documents in large print, braille or audio version.
  - Providers with Members with limited reading proficiency (LRP) may contact Molina Member Services.
    - The Molina Member Service Representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.
  - Contact Molina Member Services at:
    - Molina Complete Care for MyCare Ohio: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
    - Molina MyCare Ohio Medicaid: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Molina asks Providers to inform Molina when providing interpreter services to Molina Members. Providers may report this information to Molina by calling Molina Member Services.

Arranging for Interpreter Services

If a Member has LEP, the Provider may call Member Services for assistance with locating translation services. If a Member requires an on-site interpreter for sign language or foreign interpretation, the Provider may call Provider Services to request assistance with locating interpreter services.

Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, LRP, or limited hearing or sight are the responsibility of the Provider. Under no circumstances are Members to be held responsible for the cost of such services.

- If a Member cannot hear or has limited hearing ability, use the Ohio Relay Service/TTY at (800) 750-0750 or 711.
- If a Member has limited or no vision, documents in large print, braille or audio can be obtained by calling Member Services.
- If a Member has LRP, contact Member Services.
    - The representatives will verbally explain the information, up to and including reading the document to the Member or provide the documents in audio version.

Provider Guidelines for Accessing Interpreter Services

When Molina Members need interpreter services for health care services the Provider should:

- Verify Member's eligibility and medical benefits.
- Inform the Member that interpreter services are available.
- Contact Molina immediately if assistance in locating interpreter services is needed.

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, Healthcare Services and all other health plan functions.

Molina strongly recommends that Provider offices make an ASL interpreter available for onsite or video service delivery or make assistive listening devices available for Members who are deaf or hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

24-hour Nurse Advice Line

Molina provides Nurse Advice services for Members 24 hours per day, 7 days a week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly at (855) 895-9986 or TTY/TDD is 711. The Nurse Advice Line telephone number is also printed on membership cards.

Documentation

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

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by Molina.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of 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.

D. Culturally and Linguistically Appropriate Services

Cultural competency information, as well as languages spoken by office location, will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized Provider directory. Additionally, this information for credentialed Providers will be transmitted to the MyCare Ohio Plans on a weekly basis for them to align their directories with the information contained in the PNM.

Providers need to ensure services are delivered to Members in a culturally appropriate and effective manner by promoting cultural humility and awareness of implicit biases. Molina can provide support and training as described herein to help meet these expectations.

Culturally and Linguistically Appropriate Practices and Training

Molina is committed to reducing health care disparities, improving health outcomes for all members and partnering with Providers to collectively advance health equity. Training employees, Providers and their staff and improving appropriateness and accessibility are the cornerstones of assessing, respecting and responding to a wide variety of cultural, linguistic and accessibility needs when providing health care services. Additionally, Member input, collaboration, and quality monitoring are the cornerstones of successful culturally humble service delivery. With intentional effort to stratify health care services and health outcomes by demographic attributes such as race, ethnicity, age and sex, Molina leverages disparity reduction initiatives to advance equitable outcomes for populations groups that have been historically marginalized. Molina integrates Culturally and linguistically appropriate practices training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that culturally and linguistically appropriate practices become a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in culturally and linguistically appropriate practices and concepts for Providers and their staff. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Relations and/or online/Web-based training modules. Web-based training modules can be found on the Availity Essentials portal.

Training modules, delivered through a variety of methods, include:
1. Provider written communications and resource materials.
2. Online culturally and linguistically appropriate practices Provider training.
3. Integration of culturally and linguistically appropriate practices and concepts and nondiscrimination of service delivery into Provider communications.

Linguistic Services Background

Molina works to ensure all Members receive culturally and linguistically appropriate 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), seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic and accessibility related needs of individuals served. Molina complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color, and national origin, sex, age, and disability per title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). Molina complies with applicable portions of the Americans with Disabilities act of 1990. Molina also complies with all implementing regulations for the foregoing. 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, sexes, 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.

Molina's integration of Culturally and Linguistically Appropriate Services is reflective of the overall commitment to achieving health equity by reducing and ultimately eliminating health disparities experienced by populations that have been historically marginalized.

Additional information on culturally and linguistically appropriate services is available on the Availity Essential portal (Go to Payer Spaces, Resources Tab), from your local Provider Relations Team and by calling Molina Provider Services at (855) 322-4079.

Nondiscrimination of Health Care Service Delivery

Molina complies with Section 1557 of the Affordable Care Act (ACA). All Providers who join the Molina Provider network must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR), state law and federal program rules, including Section 1557 of the ACA.

Providers are required to do, at a minimum, the following:

1. May not limit the Provider's practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. Additionally, participating Providers or contracted Medical Groups/Independent Physician Associations (IPAs) may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. Must post in a conspicuous location in their office, a Non-discrimination Notice. A sample of the Nondiscrimination Notice can be found in the Member Handbook located at MolinaHealthcare.com.
3. Must post in a conspicuous location in the office, a Tagline Document, that explains how to access non-English language services at no cost. A sample of the Tagline Document can be found in the Member Handbook.
4. If a Molina Member is in need of accessibility-related services, you MUST provide reasonable accommodations for individuals with disabilities and appropriate auxiliary aids and services.
5. If a Molina Member needs language assistance services while at the office, and the Provider is a recipient of Federal Financial Assistance, the Provider MUST take reasonable steps to make services accessible to persons with limited English proficiency ("LEP"). Find resources on meeting LEP obligations at Limited English Proficiency (LEP) | HHS.gov and Limited English Proficiency Resources for Effective Communication | HHS.gov.
6. If a Molina Member complains of discrimination, the Provider MUST provide the Member with the following information so the Member may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR.
   - Civil Rights Coordinator at:
     - Phone: (866) 606-3889, or TTY/TDD 711.
     - Email the complaint to civil.rights@MolinaHealthcare.com
     - Members can mail their complaint to Molina at:
       Molina Healthcare, Inc.
       Civil Rights Coordinator
       200 Oceangate, Suite 100
       Long Beach, CA 90802

   - Office of Civil Rights (OCR) at:
     - Website: ocrportal.hhs.gov/ocr/portal/lobby.jsf.
     - Complaint forms are available at hhs.gov/ocr/complaints/index.html.
     - The form can be mailed to:
       U.S. Department of Health and Human Services
       200 Independence Avenue, SW

Room 509F, HHH Building
Washington, D.C. 20201

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

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources
- Assessment of Provider Network and cultural responsiveness.
- Collection of data and reporting for the Race/Ethnicity Description of Membership HEDIS® measure.
- Collection of data and reporting for the Language Description of Membership HEDIS® Measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found across the plan's subpopulations.
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

Responsibilities of Behavioral Health Providers

Molina promotes collaboration with Providers and integration of both physical and behavioral health services in effort to provide quality care coordination to Members. Behavioral health Providers are expected to provide in-scope, evidence-based mental health and SUD services to Molina Members. Behavioral health Providers may only provide physical health care services if they are licensed to do so.

Providers shall follow Quality Access to Care standards. Molina provides oversight of Providers to ensure Members can obtain needed health services within the acceptable appointment

timeframes. Please refer to the Quality section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location, and name of the Provider. This appointment must occur within seven calendar days of the discharge date. If a Member misses a behavioral health appointment, the behavioral health Provider must contact the Member within 24 hours of a missed appointment to reschedule.

E. Molina Provider Responsibilities

Nondiscrimination of Healthcare Service Delivery

Providers must comply with the nondiscrimination of health care services delivery requirements outlined in the Culturally and Linguistically Appropriate Services section of this Provider Manual.

Additionally, Molina requires Providers to deliver services to Molina Members without regard to source of payment. Specifically, Providers may not refuse to serve Molina Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

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

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

Phone: (866) 606-3889; TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

For additional information, please refer to the Department of Health and Human Services (HHS) website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment, Personnel and Administrative Services

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

Procedure to Notify MCO of Changes in Member Circumstances
Members or their authorized representatives may contact Molina Member Services to report a change in Member circumstances, such as Member address, phone number, email address, date of death or other relevant information. Members may also make updates to some of their information via the secure My Molina Member Portal.

Procedure to Notify Molina of Changes to Provider Practice in accordance with OAC rule 5160-26-05.1
Please follow the Provider update instructions outlined for the Provider Network Management (PNM) system in Section V. Provider Enrollment, Credentialling and Contracting, A. Provider Enrollment (ODM Functions) 5. Provider Maintenance, of this Manual.

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA) required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate the Provider Online Directory (POD) information at least once every 90 days for correctness and completeness. Providers must update the Provider Network Management (PNM) system as soon as possible, but no less than 30 calendar days in advance of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax or email.
- Addition or closure of office location(s).
- Addition or removal of a Provider (within an existing clinic/practice).
- Change in practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing the practice to new patients (PCPs only – see section on Provider Panel for further details).
- Any other information that may impact Member access to care.

For Provider terminations (within an existing clinic/practice), Providers must notify Molina in writing in accordance with the terms specified in your Provider Agreement.

Please visit our Provider Online Directory at MolinaHealthcare.com to validate your information. For corrections and updates that must be submitted to Molina, a convenient Provider Information Form can be found on the Provider Website.

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

All Molina Providers participating in a Medicaid network must be actively enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with ODM and meet the Medicaid Provider enrollment requirements set forth by ODM for fee-for-service Providers of the appropriate provider type.

Enrollment is available through the Provider Network Management (PNM) system, or Providers can start the process at medicaid.ohio.gov.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

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

Molina 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 (FAQs) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Molina Electronic Solutions Requirements

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

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic

remittance advice (ERA), electronic Claims appeals and registration for and use of the Availity Essentials portal.

Electronic Claims include Claims submitted via a Clearinghouse using the ODM OMES EDI process and Claims submitted through the Availity Essentials portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for Molina's Availity Essentials portal within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our website at MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

Electronic solutions/tools available to Molina Providers include:

- Electronic Claims submission options: ODM OMES EDI transactions or direct data entry via the Availity Essentials portal
- Electronic Payment: EFT with ERA.

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

Electronic Claims Submission Requirement

Providers must submit Claims electronically via the Ohio Department of Medicaid Ohio Medicaid Enterprise System (OMES) through EDI or direct data entry claims via the Availity Essentials portal.

Electronic Payment (EFT/ERA) Requirement

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

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: MolinaHealthcare.com/OhioProviders.

Molina has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/Automated Clearing House (ACH), a physical check, or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt-out of receiving a Virtual Card prior to your first payment, you may contact Molina and request that your Tax ID for payer Molina Healthcare of Ohio be opted out of Virtual Cards.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your Practice Management System is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal (providerpayments.com).

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Customer Services team at (888) 834-3511.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-year lookback.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at MolinaHealthcare.com.

Availity Essentials Portal

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

- Verify Member eligibility, covered services and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:

  - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
  - Correct/void Claims
  - Add attachments to open or pending submitted Claims
  - Check Claim status
  - View ERA and EOP
  - Create and manage Claim templates
  - Submit and manage Claim disputes, including formal appeals or reconsideration requests, for finalized Claims
  - View, dispute, resolve Claim overpayments
- Prior authorizations/service requests
  - Create and submit prior authorization/service requests
  - Check status of prior authorization/service requests
  - Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
- Download forms and documents
- Send/receive secure messages to/from Molina
- Manage Overpayment invoices (Inquire, Dispute and Resolve)

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Molina's Member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Procedure for Dismissing Non-Compliant Members

Providers may request that a Molina Member be dismissed from their practice if the Member does not respond to recommended patterns of treatment or behavior. Examples include missing scheduled appointments or failing to modify behavior that is disruptive, unruly, threatening or uncooperative.

The following steps need to be followed when dismissing a Member:
- Follow the Provider's Practice Dismissal Policy.
- Treat the Molina Member the same as a Member from another managed care organization.
- Following notification of dismissal, the PCP must offer coverage to the Member for a period of 30 days or until Molina assigns a new PCP to the Member, whichever is sooner.

This section does not apply if the Member's behavior is attributed to a physical or behavioral health condition.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by Molina prior to use. Please contact your Provider Relations Team for information and review of proposed materials.

Member Eligibility Verification

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

For more information, please refer to the Eligibility, Enrollment and Disenrollment section of this Provider Manual**.**

Member Cost Share

Providers must verify the Molina Member's cost share status prior to requiring the Member to pay co-pay, co-insurance, deductible or other cost share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost share that frees the Member from any further out of pocket charges once reached (during that calendar year).

Healthcare Services (Utilization Management and Care Coordination)

Providers are required to participate in and comply with Molina's Utilization Management and Care Coordination Programs, including all policies and procedures regarding Molina's facility admission, prior authorization, Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Molina in audits to identify, confirm and/or assess utilization levels of Covered Services.

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

In Office Laboratory Tests

Molina's Laboratory Test Payment Policy allows only certain lab tests to be performed in a Provider's office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found in the In-Office Laboratory Test List, available on the Molina Provider Website at MolinaHealthcare.com.

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites:

- Quest at appointment.questdiagnostics.com/patient/confirmation.
- LabCorp at www.labcorp.com/labs-and-appointments.

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

Claims for tests performed in the Provider's office, that are not on Molina's list of allowed in-office laboratory tests will be denied.

Treatment Alternatives and Communication with Members

Molina endorses open Provider-Member communication regarding appropriate treatment alternatives and any follow up care. Molina promotes open discussion between Providers and Members regarding Medically Necessary or appropriate patient care, regardless of Covered Benefits limitations. Providers are free to communicate all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pharmacy Program

Providers are required to adhere to Molina's drug formularies and prescription policies. For additional information please refer to the Medicare Part D section of this Provider Manual.

Participation in Quality Programs

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

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

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

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of Molina Members.

Confidentiality of Member Health Information and HIPAA Transactions

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

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

Participation in Credentialing

Providers are required to participate in credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria and applicable accreditation, state and federal requirements.

For additional information on ODM's Credentialing Program, refer to the Credentialing and Recredentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. For additional information on Molina's delegation requirements and delegation oversight refer to the Delegation section of this Provider Manual.

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members.
- Assist with coordination of care as appropriate for the Member's health care needs.
- Recommend referrals to specialists participating with Molina.
- Triage appropriately.
- Notify Molina of Members who may benefit from Care Coordination.
- Participate in the development of Care Coordination treatment plans.

Provider Panel

Participating Providers may only close their panels to new Molina Members when their panel is being closed to all new patients, regardless of insurer. Participating Providers must not close their panels to Molina Members only.

If a participating Provider chooses to close their panel to new Members, the Provider must provide 30 days advance notice to Molina. Written correspondence is required and must include the reason and the effective date of the closure. If the panel will not be closed indefinitely, correspondence should also include the re-open date.

If a reopen date for the panel is not known, the Provider will need to notify Molina when the office is ready to reopen the panel to new patients.

Disclosure Requirements

Providers are required to complete the Ownership and Control Disclosure Form during the contracting process and re-attest every 36 months or at any time disclosure must occur to ensure the information is correct and current. The forms are available on our Provider website at MolinaHealthcare.com/OhioProviders under the "Forms" tab in "Provider Forms" under "Contracted Practices/Groups Making Changes."

Access to Care Standards

For more information on Access to Care Standards, refer to the "Access to Care Standards" section in the Quality section of this Provider Manual.

V. Provider Enrollment, Credentialing, and Contracting

A. Overview

Enrollment, credentialing, and contracting are distinct yet interconnected processes. Enrollment with ODM is the initial step where providers formally join the Medicaid program. Enrollment occurs through ODM PNM system. If required, credentialing follows, requiring providers to verify their qualifications and expertise through documented evidence, ensuring they meet the necessary standards and possess the required skills. Credentialing is done through ODM. Finally, contracting involves establishing a formal agreement that outlines the specific responsibilities and expectations of both parties, ensuring clarity and mutual understanding in the professional relationship. Contracting is done through MCOP. These steps collectively ensure that providers are appropriately integrated and recognized within Molina's network.

B. Provider Enrollment (ODM Functions)

1. General Provider Information/Enrollment Information

In accordance with the Code of Federal Regulations, 42 CFR 438.608, provider enrollment with the state Medicaid agency is required to be reimbursed by the state's contracted MCOP. MCOPs are not allowed to contract with providers who are not enrolled with ODM. ODM does not have reciprocity agreements with other state Medicaid agencies or Centers for Medicare and Medicaid Services (CMS). Enrollment with the ODM is necessary even if you are enrolled with Medicaid in another state or Medicare. The enrollment process can be completed online by visiting: ODM Enrollment Process.

If you do not want to become a fully enrolled provider with ODM, but want to serve Ohio Medicaid beneficiaries, please complete the MCP Single Case Agreement in the Provider Network Management (PNM) system or use the ODM 10295 single case agreement form. If you use online enrollment in PNM, and you want your provider enrollment span to only be 120 days, you must call ODM and ask that your enrollment be truncated. The ODM 10295 form provides a 120-day agreement with Ohio. Note that multiple single case agreements are not allowed per 42 CFR 438.602.

42 CFR 438.602 also requires ODM to screen, enroll, and revalidate MCOP network providers. This law does not require MCOP network providers to render services to fee-for-service (FFS) members. Screening is like a background check to make sure a provider is qualified and credible. Revalidation is a regular check-up to confirm that the provider still meets all the necessary standards and rules over time.

Organizational provider types will be required to pay an enrollment fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFR 455.460 and in OAC 5160-1-17.8. The fee for 2025 is $730 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, ODM will require that the enrolling organizational providers submit proof of payment with their application.

Medicaid ID Requirements

In order to comply with federal rule 42 CFR 438.602, the ODM requires Providers at both the group practice and individual levels to be enrolled or apply for enrollment with Ohio Medicaid and to have an active Medicaid Identification (ID) Number for each billing National Provider Identifier (NPI).

For dates of service on or after Feb. 1, 2023, Molina denies Claims for unenrolled or inactive Providers. Providers will receive the following remit message, "N767 – The Medicaid state requires Providers to be enrolled in the Member's Medicaid state program prior to any Claim

benefits being processed," and must take action to enroll or reactivate enrollment with ODM to continue receiving payment for rendering services to Molina Members.

Ordering, Referring and Prescribing (ORP) Providers must also have an active Medicaid ID Number, except as allowed by federal and state laws or regulations. For additional details on ORP billing, please refer to the VIII. Claims Information, A. Process and Requirements for the Submission of Claims, Ordering, Referring and Prescribing (ORP) Providers NPI section of this Provider Manual.

Providers without a Medicaid ID number will need to submit an application to ODM. Enrollment is available through the Provider Network Management (PNM) system, or Providers can start the process at medicaid.ohio.gov.

2. Integrated Help Desk/ODM Provider Call Center

If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM Integrated Helpdesk at 800-686-1516 through the interactive voice response (IVR) system. It provides 24-hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system on weekdays from 8:00 a.m. through 4:30 p.m.

There are many resources available on the Ohio Department of Medicaid website about the requirements to become a participating provider. Please visit for several useful documents that answer relevant questions.

medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support

3. Termination, Suspension, or Denial of ODM Provider Enrollment

For a list of termination, suspension and denial actions initiated by ODM against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code 5164.38.

For a list of termination, suspension and denial actions initiated by ODM against a provider or applicant that allow for reconsideration, please refer to Ohio Administrative Code rule 5160-70-02.

4. Loss of Licensure

In accordance with Ohio Administrative Code rule 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

5. Enrollment and Reinstatement After Termination or Denial

If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should contact Ohio Medicaid via the Provider Enrollment Hotline ((800) 686-1516) to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

6. Helpful Information

- Medicaid Provider Resources
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support
- Federal guidelines for enrollment and screening (42 CFR 455 Subpart E)
  https://www.law.cornell.edu/cfr/text/42/part-455/subpart-E
- Ohio Revised Code
  https://codes.ohio.gov/ohio-revised-code/chapter-5160
  https://codes.ohio.gov/ohio-revised-code/chapter-3963
- Ohio Administrative Code: Ohio Department of Medicaid
  https://codes.ohio.gov/ohio-administrative-code/5160

C. Credentialing/Recredentialing (ODM Function)

General Provider Credentialing and Recredentialing Information

ODM is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the PNM system. This process adheres to the National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Providers are not able to render services to Medicaid members until they are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to OAC rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing.

It is recommended that you begin the contracting process with each MCOP you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to

render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOPs.

When you submit your initial application to be an Ohio Medicaid provider, you can designate MCOP interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOPs so they can start contracting with you.

Providers will only be included in the MCOP contract during the period credentialed or approved by ODM.

Please direct any credentialing inquiries to ODM at Credentialing@medicaid.ohio.gov or visit the website: managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

If a provider must have hospital admitting privileges to meet Molina credentialing standards, the provider must have hospital admitting privileges in order for the provider to be included in ODM's PNM system, listed in Molina's provider directory, or counted toward meeting the applicable CMS time and distance standard. The provider must indicate their admitting privileges when they join the Molina network and must also notify Molina of any changes.

D. Provider Contracting (MCOP Functions)

1. Information About the Contracting Process

Non-Contracted Providers who would like to join the Molina network are invited to complete and submit the Ohio Provider Contract Request Form available on the Molina Provider Website, on the Forms page, under the Non-Contracted Practice/Group Information header.

A sample Provider contract is available by visiting the Molina Provider Website on the Forms tab under "Provider Contract Templates."

- Molina Healthcare Dental Provider Services Agreement
- Molina Healthcare Hospital Services Agreement
- Molina Healthcare Provider Services Agreement

2. Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the MCOP and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when providers are offering different services or practitioners through the MCOP contract that are identified in the PNM system.

- Attachment A is needed for all primary care providers (PCPs) to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who agree to provide services under this plan contract.
- Attachment C is only required when the contract between the MCOP and the provider includes particular specialties rather than all specialties the provider identified in the PNM system.

The most current Medicaid Addendum is posted on the ODM website here: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda.

The Medicaid Addendum must be completed along with the MCOP provider contract.

3. Termination, Suspension, or Denial of Contract

Provider appeals process for denial of contract

Refer to your contract with Molina for details regarding termination or suspension of the contract. Molina reserves the right to deny Provider contracting requests based on the Provider network needs of our Members. A Provider who is denied a contract may apply again in one year.

4. Non-contracted or Unenrolled Providers (Out-of-State/Non-Contracted Providers)

As discussed earlier in this section, contracting and enrollment are two separate processes. Both should be completed if you want to provide services to MyCare Ohio enrolled members. Contracting is the process a provider completes with the MCOP whereas enrollment is a process completed with ODM. All providers who are billing for services for MyCare Ohio enrolled members should enroll with ODM through our PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of MCOPs." Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM 10295 form. For more information on enrolling with ODM please refer to the beginning of this section of the manual.

Provider education and training resources for PNM, including how to enroll, are located here: PSE Provider Registration Portal - Resources (maximus.com)

Out-of-state and non-contracted Providers should refer to the ODM-Designated Providers and Non-Contracted Provider Guidelines posted on Molina's website on the "Forms" page for information on:

- Member Eligibility Verification
- Prior Authorization (PA)
- Authorization Appeal and Clinical Claim Dispute Process
- Non-Clinical Claim Dispute Process

- Prescription Drugs
- Contract Requests
- Emergency Services
- Post-Stabilization Services
- Referrals
- Benefits and Payment Policy
- Claim Submission (Medical and Behavioral Health Services)
- Timely Filing Guidelines for Medicaid
- Overpayments
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)
- Sample Member Identification (ID) Cards
- Contact Information
- Cost Recovery

VI. Covered Services

A. List of Covered Services

MyCare Ohio Benefits Index

This section provides an overview of the medical benefits and Covered Services for Molina Members in accordance with OAC rule 5160-58-03.

All Covered Services must be Medically Necessary. Some are subject to prior authorization (PA) requirements and limitations. All services rendered by non-participating Providers, excluding emergency and urgent care, require PA. Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the Member's eligibility, benefit limitation/exclusions, evidence of Medical Necessity during the Claim review, and Provider status with ODM and with Molina Healthcare of Ohio

If there are questions as to whether a service is covered or requires Prior Authorization, please contact Molina at (855) 322-4079 Monday through Friday from 8 a.m. to 8 p.m. for Molina Complete Care for MyCare Ohio.

Molina Complete Care for MyCare Ohio Members will have access to all Medically Necessary services covered by CMS and the Ohio Medicaid FFS program. This includes managed long-term services and supports (MLTSS), community behavioral health and services provided in a Skilled Nursing Facility (SNF).

A. Member Cost Sharing

Cost Sharing is the Deductible, Copayment or Coinsurance that Members must pay for Covered Services provided under their Molina plan. Additional details regarding cost sharing are listed in the Summary of Benefits.

It is the Provider's responsibility to collect the copayment and other Member Cost Share from the Member to receive full reimbursement for service. The amount of the copayment and other Cost Sharing will be deducted from the Molina payment for all Claims involving Cost Sharing.

B. Services Covered by Molina

Molina covers the services described in the Summary of Benefits documentation.

For the most up-to-date coverage information, please visit MolinaHealthcare.com:

- Molina Complete Care for MyCare Ohio: On the What's Covered page, view the Benefits page, an easy-to-use list of services covered under the Molina Health Plan.
- Molina MyCare Ohio Medicaid: On the What's Covered page, view the Benefits page, an easy-to-use list of services covered under the Molina Health Plan.

Providers should utilize the Prior Authorization (PA) LookUp Tool on the Provider Website for specified services that require PA.

For information on Part D Drug coverage see Section XVI. MyCare Ohio: Medicare Part D. Molina is not required to cover pharmacy services other than the limited over-the-counter pharmacy services for our Molina Complete Care Medicaid Only members.

C. Link(s) to Molina Benefit Materials

Member benefit materials include the Summary of Benefits which can be found on Molina's website. Link(s):

- Molina Complete Care for MyCare Ohio is offered by Molina in Ohio at MolinaHealthcare.com/members/oh/en-us/mem/mycare/duals/coverd/benefits.aspx. Read the Summary of Benefits at MolinaHealthcare.com/members/oh/en-us/mem/mycare/duals/plan-materials.aspx
- Molina MyCare Ohio Medicaid is offered by Molina in Ohio at MolinaHealthcare.com/members/oh/en-us/mem/mycare/optout/coverd/benefits.aspx.

Detailed information about benefits and services can be found in the Member Handbook, available on the Member Website.

Medicaid Value-Added Benefits and Medicare Supplemental Benefits for Molina Complete Care for MyCare Ohio (dual benefits members) as presented in Member materials:

Medicaid Value-Added Benefits

Dental Care
- Extra dental checkups to keep teeth healthy.
- Up to $6,000 each year for dental treatments like fillings, crowns and dentures.

Eye Care
- $300 each year to buy glasses, contact lenses, or special lens features like tinting.

Hearing Services
- $0 hearing tests every year.
- Hearing aids covered every two years.
- Over-the-counter hearing aids for mild to moderate hearing loss.

Extra Trips on Us!
- Up to 104 one-way rides each year to places like your doctor, pharmacy or food pantries.
- Flexible options like bus passes, Uber or Lyft, and mileage reimbursement.

Social Connections Program
- Talk or chat with someone in our Compassionate Call Center any time.
- $0 smartphone and phone plan to help you stay connected, for qualifying members.
- Technology Coaches to help you use your phone or computer to access healthcare providers and benefit information.

Extras for Caregivers
- Our Caregiver Connect Program offers:
  - 8 one-way rides to visit a member in the hospital or nursing home.
  - Online support groups, helpful videos, and tips on caregiving topics.
  - Care Coaches for personal advice and support by phone.
  - On-demand caregiver certification program for expert training.
  - 40 extra hours of respite care.

Supplemental, Medicare-covered benefits
- Molina Complete Care Card: $230 each month on a pre-funded debit card for over-the-counter medicines and supplies, plus other needs like transportation, utilities like gas and electricity, and healthy foods*.
- Acupuncture.
- Chiropractic care (joint and spine care).
- Fitness.
- Home and bathroom safety modifications.
- Home-delivered meals.
- Personal emergency response system (PERS+).

- Podiatry care (foot care).
- Worldwide emergency and urgent care coverage.

*Special Supplemental Benefits (SSBCI) may be available to a member if they have chronic heart failure, cardiovascular disorders, diabetes, cancer, end-stage liver disease, or other eligible conditions. These conditions may not apply to all types of SSBCI mentioned. Eligibility for this benefit cannot be guaranteed based solely on a member's condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us.

Go mobile with Molina

- My Molina phone app to find a doctor, view your ID card, or call the 24-hour Nurse Advice Line.
- MyMolina.com, your 24/7 online connection to health care.
- Provider search tool online or in the app.

Extra benefits are subject to change. Eligibility and limitations may apply.

D. Obtaining Access to Certain Covered Services

Pharmacy

Molina is not required to cover pharmacy services other than the limited over-the-counter pharmacy services for Molina Complete Care Medicaid Only members. For information on Part D Drug coverage see Section XVI. MyCare Ohio: Medicare Part D.

Specialty Drug Services

Many specialty medications are covered by Molina through the pharmacy benefit using National Drug Codes (NDC) for billing and specialty pharmacy for dispensing to the Member or Provider.

Molina's pharmacy vendor will coordinate with Molina and ship the prescription directly to your office or the Member's home. All packages are individually marked for each Member and refrigerated drugs are shipped in insulated packages with frozen gel packs. The service also offers the additional convenience of enclosing needed ancillary supplies (needles, syringes and alcohol swabs) with each prescription at no charge. Please contact your Provider Relations Representative with any further questions about the program.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered at no cost.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor designated by Molina. More information about the Prior Authorization process, including a link to the PA request form, is available in the Health Care Services section of this Provider Manual. Physician administered drug claims require the appropriate National Drug Code (NDC) with the exception of vaccinations or other drugs as specified by CMS.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered at no cost.

Access to Behavioral Health Services

Members in need of behavioral health services can be referred by their PCP for services, or Members can self-refer by calling Molina's Behavioral Health Department by calling Molina Member Services and asking for the Behavioral Health Team. Molina's Nurse Advice Line is available 24 hours a day, seven days a week, 365 days a year for mental health or substance use disorder needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the Summary of Benefits linked above, or by contacting Molina.

- Member Services: (855) 665-4623

Specialized Recovery Services (SRS) Program

Specialized Recovery Services Program (SRS) means the Home and Community-Based Services (HCBS) Program jointly administered by ODM and the Ohio Department of Mental Health and Addiction Services (ODMHAS) to provide services to individuals with qualifying diagnoses of severe and persistent mental illness or diagnosed chronic conditions.

Recovery Management (RM)

The recovery management service consists of an SRS RM Guide: SRS Recovery Manager working with an SRS-eligible individual to develop an SRS person-centered care plan. An SRS Recovery Manager will meet with individuals regularly to monitor their plan and the receipt of SRS under an individual's person-centered care plan. SRS Recovery Managers may also provide information and referrals to other services.

Individualized Placement and Support-Supported Employment (IPS-SE)

IPS-SE are activities that help individuals find a job if they are interested in working. An IPS-SE qualified worker will evaluate and consider an individual's interests, skills, experience, and goals as it relates to employment goals. IPS-SE Programs also provide ongoing support to help individuals successfully maintain employment.

Peer Recovery Support

Peer recovery support is provided by individuals who utilize their own experiences with mental health to help individuals identify and reach their recovery goals. Individualized recovery goals will be incorporated into the SRS person-centered care plan designed by the individual based on their preferences and the availability of community and natural supports. The peer relationship can help individuals focus on strategies and progress toward self-determination, self-advocacy, well-being, and independence.

Non-Emergency Medical Transportation

For Molina Members who have non-emergency medical transportation as a Covered Service, Molina covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). Examples of non-emergency medical transportation include, but are not limited to, lift vans and wheelchair-accessible vans. Members require Prior Authorization from Molina for air ambulance services before the services are rendered. Prior Authorization is not required for vans, taxi, etc., where they are covered benefits. Additional information regarding the availability of this benefit is available by contacting Provider Services at (855) 322-4079.

Preventive Care

Preventive Care Guidelines are located on the Molina website. Please use the link below to access the most current guidelines.

MolinaHealthcare.com/providers/oh/duals/resource/prevent.aspx

Molina needs your help conducting these regular exams in order to meet the targeted state and federal standards. If you have questions or suggestions related to preventive care, please call our Health Education line at (866) 891-2320.

Immunizations

Adult Members may receive immunizations as recommended by the Centers for Disease Control and Prevention (CDC) and prescribed by the Member's PCP.

Immunization schedule recommendations from the AAP and/or the CDC are available at the following website: cdc.gov/vaccines/schedules/hcp/index.html.

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

Prenatal Care

Stage of Pregnancy	How often to see the doctor
1 month – 6 months	1 visit a month
7 months – 8 months	2 visits a month

Stage of Pregnancy	How often to see the doctor
9 months	1 visit a week

Nurse Advice Line

Members may call the Nurse Advice Line any time they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, 365 days a year to assess symptoms and help make good health care decisions.

English Phone: (855) 895-9986
TTY/TDD: 711 Relay

The registered nurses who staff the Nurse Advise Line do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care (LOC) following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the Emergency Room. By educating Members, it reduces costs and over utilization on the health care system.

Molina is committed to helping our Members:
- Prudently use the services of your office.
- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the emergency room (ER).

E. Health Management Programs

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members.

Health Education/Disease Management

Molina offers programs to help our Members and their families manage chronic health conditions. The programs include telephonic outreach from our clinical staff and health educators along with access to educational materials. You can refer Members who may benefit from the additional education and support Molina offers. Members can request to be enrolled or disenrolled in these programs at any time.

Molina provides health management programs designed to assist Members and their families to better understand their chronic health condition(s) and adopt healthy lifestyle behaviors. The programs include::
- Tobacco cessation
- Weight management

- Nutrition consult

Phone: (833) 269-7830 (main line) or (866) 472-9483 (healthy lifestyle programs)
Fax: (800) 642-3691

F. Telehealth and Telemedicine Services

Molina supports and encourages Providers to make telehealth services available to Members as appropriate. To find additional resources and training regarding telehealth, visit the You Matter to Molina page on our website. Providers shall comply with all operating policies and procedures adopted by Molina both for providing telehealth services, as described below, as well as taking into account all other areas of this manual that have implications for telehealth, including:

- Benefits and Covered Services
- Claims and Compensation
- Compliance

Telehealth definitions and eligible Provider types are available in OAC 5160-1-18 Telehealth.

Molina must also cover telehealth services as specified in the ODM Telehealth Services: Guidelines for Managed Care Entities manual available on the ODM website.

Molina Members may obtain Covered Services by participating Providers, through the use of Telehealth and Telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and participating Provider are in the same physical location.
- Services do not include texting, facsimile, or email only.
- Services include preventive and/or other routine or consultative visits during a pandemic.
- Member cost sharing associated to the Schedule of Benefits based upon the participating Provider's designation for Covered Services (i.e., Primary Care, Specialist or other Practitioner).
- Covered Services provided through store-and-forward technology, must include an in-person office visit to determine diagnosis or treatment.

Note: Telehealth does not replace provider choice and/or member preference for in-person service delivery.

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

- **Benefits:** Payment may be made only for Medically Necessary health care services identified in Appendix A of OAC 5160-1-18 Telehealth when delivered through the use of telehealth from the practitioner site. Please consult OAC 5160-1-18 Telehealth for additional details.

  Benefits are not provided for any technical equipment or costs for the provision of telemedicine services. The following are additional provisions that apply to the use of Telehealth and Telemedicine services:

- **Member Eligibility and Consent for Telehealth Services:** Molina allows any Member to access telehealth services. There are no criteria for Member geography or physical proximity to Providers. Molina acknowledges that depending on a Member's situation, a Member may find additional convenience through telemedicine, even if they live in an area with many Providers located a short distance from their home.

  Organizations and health professionals providing telehealth services shall ensure compliance with relevant legislation, regulations, and accreditation requirements for supporting Member decision-making and consent.

- Special Populations:
  1. English as a second language – Provide and document the use of an interpreter.
  2. Comply with the Americans with Disabilities Act of 1990 (ADA) and other legal and ethical requirements.
  3. Homebound/Geriatric – Providers should have the patient affirm consent to family members, caregivers, and nurses that would facilitate the visit and decision-making. If the patient is in a care facility or senior living community, a trained technician may assist in collecting relevant clinical information, including medical records, lab or diagnostic testing, and access to caregivers and staff. Providers should take into account the special needs of the elderly; and take these into account when designing and choosing technology configurations for telehealth equipment and systems.

  The Member, or their guardian, needs to have the option to consent to the use of telehealth for services instead of in-person delivered care. This consent shall be documented and include:
  a. The description, so a Member understands how telehealth service compares to in-person delivered care. Apprise a Member of their rights when receiving telemedicine, including the right to suspend or refuse treatment.

b. Apprise a Member of their own responsibilities when participating in telehealth.
c. Inform Member of a formal complaint or grievance process used to resolve ethical concerns or issues that might arise as a result of participating in telehealth.
d. Record keeping, including the process by which Member information will be documented and stored.
e. Discuss the limits to confidentiality in electronic communication. Discuss the potential benefits, constraints, and risks (e.g., privacy and security) of telehealth.
f. Go over potential risks, and include an explicit emergency plan (particularly for Members in settings without access to clinical staff). The plan should include calling the Member via telephone and attempting to troubleshoot the issue together. It may also include referring the Member to another Provider or completing the encounter by voice only.
g. Credentials of the practitioner site Provider and billing arrangements. Information provided shall be in simple language that can easily be understood by the Member.
h. When going over the potential for technical failure, a contingency plan is communicated to the Member in advance of the telehealth encounter.
i. Procedures for coordination of care with other professionals.
j. A protocol for the contact between visits.
k. Prescribing policies that include local and federal regulations and limitations.
l. Conditions under which telehealth services may be terminated and a referral made to in-person care.
m. Description of the appropriate physical environment free from distractions, conducive for privacy, in proper lighting, and minimizing background noise.
n. Inform Members and obtain the Member's consent when students or trainees observe the encounter.
o. Member shall consent in writing prior to any recording of the encounter.

- **Privacy and Security:** Please refer to the IV. Provider Responsibilities, B. HIPAA and PHI section of this Provider Manual for more information.

- **Provider Directory Listing:** Molina offers a visual icon in our Provider Online Directory (POD) that indicates whether a Provider offers any telehealth services. Please notify your Provider Services Team as soon as possible if your organization adds telehealth capabilities, so we can update this data field and identify this option appropriately.

For additional information on Telehealth and Telemedicine Claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

G. Provider Education on Covered Benefits and Member Access to Care

Providers are educated on the tools and information required to ensure Members understand their benefits and how to access care. This includes but is not limited to:

- How to identify MyCare Ohio Benefits by accessing the appropriate plan or state agency materials.
- How to access Covered Services including waiver services such as MLTSS, In-Home Supportive Services (IHSS) or Behavioral Services.

B. Requirements Regarding the Submission and Processing of Requests for Specialist Referrals

Referrals

Molina maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no PA is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

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

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

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to Molina.

Molina will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Molina UM department. Referrals to specialty care outside the network require PA from Molina. All PA requests are reviewed for Medical Necessity.

Access to Behavioral Health Providers and PCPs

Members may be referred to an in-network behavioral health Provider via referral from a PCP, medical specialists or by Member self-referral. PCPs are able to screen and assess Members for

the detection and treatment of any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health service within the scope of their practice and in compliance with all state and regulatory requirements for the service provision. A formal referral form or Prior Authorization is not needed for a Member to self-refer or be referred to a PCP, specialist or behavioral health Provider. However, individual services provided by non-network behavioral health Providers will require PA.

Members may be referred to PCP and specialty care Providers to manage their health care needs. Behavioral health Providers may refer a Member to an in-network PCP, or a Member may self-refer. Behavioral health Providers may identify other health concerns, including physical health concerns, that should be addressed by referring the Member to a PCP.

Supplemental Services

A referral from the Member's PCP is not required for mandatory supplemental benefits.

Please refer to the Member Summary of Benefits for more information – a link is available above under "Links to Benefit Materials."

Molina partners with Providers/vendors for certain services. To find an in-network Provider/vendor, please refer to the Provider Online Directory on Molina's website at MolinaHealthcare.com.

Molina offers supplemental benefits for all Molina Members. Supplemental benefits can be either mandatory, meaning all Members on the plan are eligible for that supplemental benefit or considered Special Supplemental Benefits for the Chronically Ill, referred to as SSBCI. As per CMS, SSBCIs are only available to Members who meet specific criteria by having certain chronic conditions that qualify them for a specific benefit.

A request for a SSBCI can be sent directly to Molina's care management department who will verify and validate the Member has the qualifying diagnosis. Verification of qualifying criteria may require confirmation directly with our Providers in which a member of our care management team will reach out to your office. We appreciate your assistance with this process and your support to ensure that all SSBCIs are provided as CMS had intended. Depending on the plan, SSBCI benefits may include food and produce.

C. Transportation

Transportation Vendor Contact Information

Vendor: Access2Care

Phone: (866) 282-4836

- Routine: 7 a.m. to 7 p.m. EST, Monday through Friday for routine appointments.

- Urgent: 24 hours per day, 7 days a week

Email: CareManagementteam@mtm-inc.net

Transportation Policies/Coverage

Transportation is covered for up to 104 one-way per calendar year for Medically Necessary appointments and Women, Infants and Children (WIC) or County Department of Job and Family Services (CDJFS) Medicaid redetermination appointments for Molina Complete Care for MyCare Ohio (dual benefits) members. Transportation is also available for all Members to receive a medically necessary Medicaid-covered service if the Member lives greater than 30 miles from the nearest network Provider. All Members may receive transportation for trips under 30 miles to attend their annual wellness visit and to receive dialysis, chemotherapy, community behavioral health and prenatal and postpartum services. OhioRISE Members' transportation needs will be included in their transition plans as needed. It is important to arrange transportation at least 48 hours before the appointment.

D. Emergency Services

Emergency Medical Conditions means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant Member, the health of the Member or their unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services means: covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. Providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with a Managed Care Organization.

Emergent and urgent care Services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

Emergency Services, Urgent Care and Post-Stabilization Services

Molina covers Emergency Services as well as Urgently Needed Services and Post-Stabilization Care for Members in accordance with applicable federal and state law.

Medicare defines Emergency Services as covered services provided to evaluate or treat an Emergency Medical Condition. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a

prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Serious jeopardy to the health of the individual or, in the case of a pregnant Member, the health of the Member or their unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Urgently Needed Services are Covered Services that:

1. Are not Emergency Services, but are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition;
2. Are provided when (a) the Member is temporarily absent from the Molina plan's service area and therefore, the Member cannot obtain the needed service from a network Provider; or (b) when the Member is in the Molina plan's service area but the network is temporarily unavailable or inaccessible; and
3. Given the circumstances, it was not reasonable for the Member to wait to obtain the needed services from their regular plan Provider after returning to the service area or the network becomes available.

Post-Stabilization Care Services are Covered Services that are:

1. Related to an Emergency Medical Condition;
2. Provided after the Member is stabilized; and
3. Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition.

Providers requesting an inpatient admission as a post stabilization service must request this type of service by contacting Molina at (855) 322-4079.

Emergency Services and Urgently Needed Services do not require pre-authorization, although contracted Provider notification requirements may apply. See Emergent Inpatient Admissions section below.

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

Molina provides Members a 24 hour Nurse Advise Line for medical advice. The 911 information is given to all Members at the onset of any call to the plan.

Emergency Mental Health or Substance Use Disorder Services

Members are directed to call 911 or go to the nearest emergency room if they need Emergency Services mental health or substance use disorder services. Examples of emergency mental health or substance use 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

Behavioral Health Crisis Lines

Molina has a Behavioral Health Crisis Line that may be accessed by Members 24 hours a day, 7 days a week, 365 days a year. The Molina Behavioral Health Crisis Line is staffed by behavioral health clinicians to provide urgent crisis intervention, emergent referrals and/or triage to appropriate supports, resources, and emergency response teams. Members experiencing psychological distress may access the Behavioral Health Crisis Line by calling the Member Services telephone number listed on the back of their Molina Member ID card or by calling the Nurse Advice Line.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone with concerns about someone else) can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year by dialing 988 from any phone.

Out-of-Area Emergencies Mental Health or Substance Use Services

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

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

For out-of-area Emergency Services, plans will be made to transfer Members to an in-network facility when Member is stable.

Emergency Transportation

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

E. Benefit Manager Contact Information and Service Information

Dental (SKYGEN USA, LLC)

Molina partners with SKYGEN USA, LLC, a nationwide leader in managed benefits administration, to administer the dental benefit for our Members.

Phone: (855) 322-4079 option 7

SKYGEN Portal Phone: (844) 621-4589
Hours of Operation: 8 a.m. – 8 p.m.
Website: pwp.skygenusasystems.com
Email: providerportal@skygenusa.com

March Vision

March Vision will process and pay benefit-eligible service codes regardless of diagnosis code when the Member is benefit eligible for the service code billed. March Vision will process Claim payments to optometrists, opticians and ophthalmologists.

Website: marchvisioncare.com
Phone: (844) 75-MARCH or (844) 756-2724
Hours of Operation: 8 a.m. – 8 p.m.

For additional information, read the March Vision State Specific Plan Benefits and Requirements at marchvisioncare.com/providerreferenceguides.aspx.

F. Non-Covered Services

Molina will not pay for the following services or supplies which are not covered by Medicaid:

- Services that are experimental in nature and are not performed in accordance with standards of medical practice.
- Services that are related to forensic studies.
- Autopsy services.
- Services for the treatment of infertility.
- Abortion services that do not meet the criteria for coverage in accordance with Ohio Administrative Code rule 5160-17-01.
- Services pertaining to a pregnancy that is a result of a contract for surrogacy services.
- Assisted suicide and other measures taken actively with the specific intent of causing or hastening death; and
- Services that do not meet the criteria for coverage set forth in any other rule in Ohio Administrative Code Agency 5160.

G. Grievance, Appeal and State Hearing Procedures and Time Frames per OAC Rule 5160-26-05.1

Appeals, Grievances and State Hearings

Molina maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased, and appropriate resolutions. Molina Members, or their authorized

representatives, have the right to voice a grievance or submit an appeal through a formal process.

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

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

Definitions

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP): A Plan that provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract with the applicable State; that meets certain coverage requirements defined by Federal law; and that coordinates the delivery of covered Medicare and Medicaid services using aligned care coordination and specialty care network methods for high-risk beneficiaries. FIDE SNPs are subject to the Unified Grievance and Appeals procedures provided under Federal law and rules.

The Ohio Administrative Code defines a grievance (complaint) as an expression of dissatisfaction with any aspect of Molina's or a participating Providers' operations, provision of health care services, activities or behaviors. Examples of a grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Molina employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, Plan benefit design, or the coverage decision or Appeals process, the Plan formulary, or the availability of contracted Providers.

For a FIDE SNP and certain HIDE SNPs, a Grievance is referred to as an Integrated Grievance because the Member's complaint may qualify as a Grievance under Medicare or Medicaid rules. Integrated Grievances follow a Unified Grievances process.

An Adverse Benefit Determination includes, among other things, the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; the reduction, suspension, or termination of a previously authorized service, or the denial, in whole or in part, of payment for a service.

An appeal is the request for a review of an adverse benefit determination. The Member or their authorized representative has the right to appeal Molina's decision to deny a service.

For plans providing integrated Medicare and Medicaid benefits, an Appeal includes procedures that deal with the review of adverse initial determinations made by the Plan on the health care services or benefits under the Member's Medicaid coverage under the Plan. For FIDE SNPs and certain HIDE SNPs, Appeals are called Integrated Appeals because they incorporate Medicare and Medicaid processes. Integrated Appeals follow a Unified Appeals process. Appeals involving Medicaid-covered services or Medicare-Medicaid overlap services for an MMP may follow procedures that vary from standard Medicare rules.

Integrated appeal**:** The procedures for an appeal for an applicable integrated plan. An integrated appeal includes an integrated reconsideration (a Level 1 appeal by an applicable integrated plan for other than a Part D drug). An integrated appeal is applicable for the Member's Medicare (Part C) and Medicaid benefits, whether the request involves coverage by Medicare, Medicaid, or both. Integrated appeals follow procedures outlined in federal rules and the D-SNP's contract with the State Medicaid Agency. (Part D Appeals for Applicable Integrated Plans continue to follow Part D procedures).

The Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO or QIO) is a Medicare organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review beneficiary complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care organizations, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review Medicare continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care Provider (e.g., physician, hospital, etc.) and the beneficiary. This definition is relevant for Members enrolled in the Molina Complete Care for MyCare Ohio plan.

For a FIDE SNP and certain HIDE SNPs, an Organization Determination is called an Integrated Organization Determination because the term includes adverse benefit determinations under Medicaid. MMPs may use the term(s) Adverse Action and/or Adverse Benefit Determination in place of the term Organization Determination and may include additional circumstances within the definition such as the denial of a member's request to obtain services outside the network when the member resides in a rural area and there is only one Plan in the area and the denial of a Member's request to dispute a financial liability.

Filing an Appeal or Member Grievance

Members may file an appeal or grievance at any time by calling Molina's Member Services Department at:

- Molina Complete Care for MyCare Ohio plan: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

- Molina MyCare Ohio Medicaid: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

Members may also submit a Molina MyCare Ohio Medicaid grievance or appeal at any time in writing to:

Molina Healthcare of Ohio, Inc.
Attn: Provider Appeals and Grievance Department
PO Box 182273
Chattanooga, TN 37422

Fax: (866) 713-1891

Members may also submit a Molina Complete Care for MyCare Ohio plan grievance or appeal in writing to:

Molina Healthcare
Attn: Provider Appeals and Grievance
PO Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610

Members may authorize a designated representative to act on their behalf (hereafter referred to as "representative"), with written consent. The representative can be a friend, a family member, health care Provider, or an attorney.

- For Medicaid, a Grievance/Appeal Request Form can be found on Molina's Member and Provider Websites at MolinaHealthcare.com.
- For the Molina Complete Care for MyCare Ohio plan, the Member may be required to provide a CMS Appointment of Representative Form (CMS1696) or documentation of legal surrogacy (e.g., through a Power of Attorney or guardianship). The AOR Form can be found online and downloaded at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

A verbal standard appeal may be accepted from Members enrolled in Plans providing integrated Medicare and Medicaid benefits, such as a FIDE SNP.
For Plans providing integrated Medicare and Medicaid benefits, the Member may be allowed to file a Grievance related to their Part C or Medicaid coverage at any time.

Grievances Process and Timeline

Molina will investigate, resolve and notify the Member or their authorized representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a

grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following time frames:

- Two working days of receipt of a grievance related to accessing Medically Necessary Covered Services in the Molina Complete Care for MyCare Ohio line of business (unless an extension is requested from and approved by ODM)
- Grievances are typically responded to within 30 days. The plan may also be allowed to take an extension under certain circumstances (with some variability for certain types of Grievances for Plans providing integrated Medicare and Medicaid benefits, such as a FIDE SNP).

Member Appeals

For Member appeals represented by the Provider, Molina must have written consent from the Member authorizing someone else to represent them. An appeal will not be reviewed until the Member authorization is received. A Grievance/Appeal Request Form can be found on Molina's Member website at MolinaHealthcare.com.

Providers can request expedited or standard pre-service Appeals on behalf of their Members who are enrolled in the Molina Complete Care for MyCare Ohio plan. However, if not requested specifically by a treating physician, a CMS Appointment of Representative Form may be required. The Appointment of Representative Form can be found online and downloaded at cms.hhs.gov/cmsforms/downloads/cms1696.com.

An appeal can be filed verbally or in writing within 60 days from the date of the denial notice. Molina will send a written acknowledgement in response to written appeal requests received. Molina will respond to the Member or representative in writing with a decision within 15 calendar days (unless an extension is granted to Molina by ODM).

When submitting an Appeal for a Member, provide all medical records and/or documentation to support the Appeal at that time. Please note that if additional information must be requested, processing of the Appeal may be delayed. Members should include their name, contact information, Member ID number, health plan name, reason for appealing, and any evidence the Member wishes to attach. Members may send in supporting medical records, documentation or other information that explains why Molina should provide or pay for the item or service.

Appeals Process and Timeline

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

Expedited Member appeals may be requested by the Member or their authorized representative orally or in writing. Molina will make the determination within one business day

to whether to expedite the appeal resolution. Molina will make reasonable efforts to provide prompt oral notification to the member or representative of the decision to expedite or not expedite the appeal resolution. Molina will resolve the appeal as expeditiously as the member's health condition requires, but the resolution time frame shall not exceed seventy-two hours from the date Molina received.

The Member or representative will be notified. No punitive action will be taken against a Member, Member's representative, or Provider for filing an expedited Member appeal or against any Provider who supports a Member's request for an expedited appeal.

If Molina denies the request for an expedited resolution of an appeal, the appeal will be treated as a standard appeal and resolved within 15 calendar days from the receipt date (unless an extension was granted).

Additional timeframes apply for Medicare-related Appeals for Members in the Molina Complete Care for MyCare Ohio plan:

Expedited Pre-Service (non-Part B, non-Part D drug)	72 hours
Expedited Pre-Service Part B drug	72 hours
Expedited Pre-Service Part D drug	72 hours
Standard Pre-Service (non-Part B, non-Part D drug)	30 calendar days
Standard Pre-Service Part B drug	7 calendar days
Standard Pre-Service Part D drug	7 calendar days
Standard Post-Service (Part C)	60 calendar days
Standard Post-Service Part D drug	14 calendar days

Extensions are not allowed for Appeals involving Part B and Part D drugs. Molina's Pharmacy Department manages all Part D Appeals.

Time frames for fully integrated plans such as a FIDE SNP may vary with regulatory and contractual requirements.

State Hearing

If the appeal resolution affirms the denial, reduction, suspension, or termination of a Medicaid-Covered Service, or if the resolution permits the billing of a Member due to Molina's denial of payment for that service, Molina will notify the Member of their right to request a state hearing.

A Member has the right to request a state hearing from the Bureau of State Hearings 90 days from the appeal resolution notice if there is dissatisfaction with Molina's decision. The Member or representative is required to file an appeal with Molina prior to requesting a state hearing.

Members are notified of their right to a state hearing in all the following situations:

- A service denial (in whole or in part)
- Reduction, suspension or termination of a previously authorized service

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

Appeal decisions not wholly resolved in the Member's favor will include information on how to request a state hearing and the members right to request a continuation of benefits during an appeal or state hearing and specification that at the discretion of ODM the member may be liable for the cost of any such continued benefits. If the state hearing upholds Molina's decision, and continued benefits were requested in the interim, the Medicaid Member may be responsible for payment. The provider has the right to participate in these processes on behalf of the provider's patients and to challenge the failure of the MCE to cover a specific service.

For Members in the Molina Complete Care for MyCare Ohio plan, the Member may have the right to pursue a State Fair Hearing when the item or service is or could be covered by Medicaid or both Medicare and Medicaid (overlap). In these cases, when the decision is partially or completely adverse to the Member, the Member is provided with their State Fair Hearing rights and any instructions for continuation of benefits pending State Fair Hearing. Additional levels of Appeal follow applicable State rules and requirements. When the item or service is or could be covered by Medicare or both Medicare and Medicaid (overlap) and the decision is partially or completely adverse to the Member, the Appeal will be forwarded to an Independent Review Entity (IRE). (For Part D upholds, the Member must request review by the IRE.) The IRE is a CMS contractor independent of Molina. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an Administrative Law Judge (ALJ) or attorney adjudicator. Additional levels of Appeal are available to the Member if amount in controversy requirements are met, including appeal to the Medicare Appeals Council (MAC) and federal court. Members may pursue both the Medicare and the Medicaid additional levels of Appeal when applicable.

Continuation of benefits (aka "Aid Continuing")

Members enrolled in a Plan providing integrated Medicare and Medicaid benefits (e.g., a FIDE SNP) may be entitled to continue benefits pending appeal if authorization for services is terminated, suspended or reduced prior to the expiration of the authorization period. This typically occurs with Medicaid-covered services such as personal care services but can be applicable to other Medicare or Medicaid services not authorized for a limited, defined benefit period when the services are terminated, suspended, or reduced prior to the expiration of the authorization period. The right to continue benefits is subject to the filing of the Appeal and/or providing a written request for continuation of benefits within ten (10) calendar days of the date of the notice of suspension, termination, or reduction or the expiration of the authorization, whichever is later. The right to request continuation of benefits typically resides

with the member. When Providers are allowed to request continuation of benefits under applicable federal and state regulations, they may be required to have the written consent of the Member to file the Appeal.

If the Member's Appeal is upheld by the Plan, their notice of the Appeal decision will contain any instructions for continuation of benefits pending State Fair Hearing.

Federal and state rules applicable to the specific Plan determine whether recovery of costs applies if the Member receives an adverse decision on Appeal or at State Fair Hearing.

Medicare Hospital Discharge Appeals

Discharges for a Medicare-covered hospital stay are subject to an expedited Member Appeal process. This process is available for Medicare-covered hospital stays for Members enrolled in the Molina Complete Care for MyCare Ohio plan. Members receive their appeal rights through the delivery of the Important Message from Medicare (IM, Form CMS-10065) by the hospital. For additional information on delivery of the IM, see the Termination of Inpatient Hospital Services section of this Provider Manual.

Members disputing their discharge decision may request an immediate Appeal to the QIO for the service area. (In Ohio, the BFCC-QIO is Commence Health.) The member must appeal to the QIO as soon as possible and no later than the planned discharge date and before the member leaves the hospital. The QIO will typically respond within one day after it receives all necessary information.

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care beginning at noon of the calendar day following the day the QIO provides notice of its decision to the Member. The Member may request a reconsideration from the QIO if they remain in the hospital. If the QIO continues to agree with the discharge decision, the Member may appeal to an Administrative Law Judge (ALJ) or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care without proper notification that includes their appeal rights located within the IM. The Member will then have an opportunity to appeal that subsequent discharge determination.

If the Member misses the deadline to file an appeal with the QIO and is still in the hospital, the Member (or their authorized representative) may request an expedited pre-service appeal with the Plan. In this case, the Member does not have financial liability for paying for the cost of additional hospital days beyond the discharge date if the original decision to discharge is upheld.

SNF, CORF and HHA Discharge Appeals

Another Medicare appeal process available to Molina Complete Care for MyCare Ohio plan Members involves discharges from care provided by a skilled nursing facility (SNF) (including a swing bed in a hospital providing Medicare Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF), or home health agency (HHA). These discharges are subject to an expedited (fast track) Member appeal process. For this purpose, a discharge means the complete termination of services and not the termination of a single service when other services continue (e.g., when the Member is receiving skilled nursing, skilled therapy, and home health aide services from an HHA and only the home health aide services are terminated while the other services continue). When a single service is terminated and other services continue, an Integrated Denial Notice (IDN) with Member appeal rights is issued to the Member. Members receive their discharge appeal rights through the delivery of the Notice of Medicare Non-Coverage (NOMNC) by the SNF, CORF, or HHA. For additional information on delivery of the NOMNC, see the Termination of SNF, CORF, and HHA Services section of this Provider Manual.

Members disputing their discharge decision may request an expedited (fast-track) appeal to the QIO for the service area. (The BFCC-QIO for Ohio is Commence Health.) The Member must appeal to the QIO by noon of the calendar day after the NOMNC is delivered. The QIO will typically respond by the effective date provided in the NOMNC (the last covered day).

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care received beyond the last covered day provided in the NOMNC. The Member has an opportunity to request a reconsideration form the QIO if they remain in the SNF or continue to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC. If the QIO continues to agree with the discharge decision, the Member may appeal to the Administrative Law Judge (ALJ) or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care without proper notification that includes their appeal rights located within the NOMNC. The Member will then have the opportunity to appeal that subsequent termination of services (discharge) determination.

If the Member misses the deadline to file an appeal with the QIO and is still in the SNF or continuing to receive services form the CORF or HHA beyond the last covered day provided in the NOMNC, the Member (or their authorized representative) may request an expedited pre-service appeal with the Plan. In this case, the Member does not have financial protection during the course of the expedited pre-service appeal and may be financially liable for paying for the cost of additional services provided beyond the discharge date (last covered day) if the original decision to discharge is upheld.

Obtaining Additional Information about the Member Appeal Process

For additional information about Member Appeal rights, call Provider Services at (855) 322-4079, or 711, for persons with hearing impairments (TTY/TDD). A detailed explanation of the Appeal process is also included in the Member's Member Handbook. If Members have additional questions, please refer them to Member Services.

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of 10 years. In addition to the information documented electronically via call tracking in Molina's centralized database or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain records for a period not less than 10 years from the termination of the model contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Molina's prior approval for the disposition of records if Agreement is continuous.)

H. MyCare Ohio Billing Guidelines

Providers should reference the following:

- ODM Billing Guides
- CMS Billing Guides

Advanced Practice Nurses (APN)

When billing for any service provided by an APN, all services must be billed with the appropriate modifier to denote the type of APN that provided the service.

APN services will be reimbursed, in accordance with OAC 5160-4-04 Advanced Practice Registered Nurses (APRN) Service.

Anesthesia Services

Per OAC 5160-4-21 Anesthesia Services, Molina requires all anesthesia services to be billed with the number of actual minutes in the unit's field of the CMS-1500 form.

Anesthesia services will not be paid for surgeries that are non-covered.

Bilateral Surgery

Bilateral procedures performed – reference OAC 5160-4-22 Surgical Services for physician Claims.

Bilateral surgeries are procedures performed on both sides of the body at the same operative session or on the same day (two ears, two feet, two eyes, etc.).

Billing for Preventive and Sick Visits on the Same Date of Service

Molina will pay for both a new/established patient preventative/well visit with a new/established patient sick visit for the same Member on the same date of service if the diagnosis codes billed support payment of both codes.

Chronic Conditions

In order for Molina to accurately identify Members with chronic conditions that may be eligible for one of the Disease Management or Care Coordination Programs, please see the suggested billing tips listed below:

- For Members with chronic illness, always include appropriate chronic and disability diagnoses on all Claims.
- Document chronic disease (please note, Molina has identified asthma as the most common diagnosis code not reported) whenever it is appropriate to do so. This includes appointments when prescription refills are written for chronic conditions.
- Be specific on diagnosis coding; always use the most specific and appropriate diagnosis code available.

Diagnostic Pointers

A single encounter may frequently correlate with multiple procedures and/or diagnosis codes. Diagnosis pointers are required if at least one diagnosis code appears on the Claim and must be present with the line item with which it is associated.

A pointer should be submitted to the Claim diagnosis code in the order of importance. The remaining diagnosis pointers are used in a declining level of importance to the service line. Please reference the appropriate ODM Companion Guide (837P), found on the ODM website at medicaid.ohio.gov/, for the appropriate loop and segments.

Dialysis Services

Molina requires one service line per date of service with a maximum unit of one for dialysis services. If a Claim is received with a date span billing multiple units on a single charge line, the charge line will be denied.

Durable Medical Equipment

Molina follows the DME guidelines as referenced in the OAC 5160-10-01 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers. It is imperative that appropriate billing be used to identify the services provided and process Claims accurately.

Find additional information in:

- 5160-10-01 Appendix – Medicaid Supply List
- ODM Home & Durable Medical Equipment Providers
- Medicare Claims Processing Manual 100-04, Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Durable Medical Equipment (DME), Medical Supplies, and Parenteral Nutrition

Molina billing requirements are:

- Submit one service line per each date of service
- Use the shipping date as the date of service on the Claim if a shipping service or mail order is utilized
- Always include the appropriate modifier on all DME Claims for rent to purchase items listed in the Ohio Medicaid Supply List

Enteral Nutrition Formula – B Code Products

Starting on June 1, 2023, for dates of service on or after June 1, 2023, HCPCS B4157-B4162 for Enteral Nutrition requires an invoice for pricing, as well as require an NDC. Claims will be priced at 185% of the provider's cost multiplied by the contractual agreement.

For information on submitting the invoice attachment with the claim, refer to the Reference Guide for Supporting Documentation for Claims on the You Matter to Molina page.

Please refer to the ODM supply list and OAC 5160-10-01 Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers for further details. Additional information is available on the Molina Provider Website Healthchek-EPSDT page.

Electronic Claims

For detailed information on EDI claim submission, please reference the appropriate ODM Companion Guides found on the ODM website at medicaid.ohio.gov.

Home Health Services

Providers should reference OAC 5160-12-01 Home Health Services: Provision Requirements, Coverage and Service Specification for a list of covered home health services, eligibility requirements and billing guidelines.

Home Health Services for Member and Baby after Delivery:

- HQ modifier must be appended to both member and baby's Claim, indicating a group visit.
- Find additional information in OAC 5160-12-05 Reimbursement: Home Health Services and OAC 5160-12-04 Home Health and Private Duty Nursing: Visit Policy.

Inpatient Emergency Room (ER) Admissions

Molina requires medical records with the initial Claim submission. This is required so the Claim can be reviewed for an inpatient authorization if the authorization is not on file due to the emergency situation.

Interim Claims – Type of Bill (TOB) 112, 113, and 114

Interim Claims should be submitted to Molina based on the Ohio Medicaid Hospital Billing Guidelines. Upon discharge of a Molina Member, the inpatient hospital Claim should be submitted with the complete confinement on a Claim with TOB 111 if interim Claims were previously processed. Molina requires a Claim with complete confinement to ensure accurate Claim payment.

Locum Tenens Services Substituting for an Absent Provider

A Molina contracted Provider may arrange for a temporary replacement to provide services to their patients as an independent contractor for a limited time due to an illness, a pregnancy, vacation, etc. This is known as a locum tenens arrangement.

- Billing and Documentation Requirements can be found in OAC 5160-1-80 Substitute practitioners (locum tenens)
- Locum Tenens Provider Requirements can be found in OAC 5160-1-80 Substitute practitioners (locum tenens)

Maternity Care

Last menstrual period (LMP) date requirement: Molina requires the LMP date on pregnancy-related services billed on a CMS-1500 in accordance with OAC 5160-26-06 Managed Health Care Programs: Program Integrity – Fraud and Abuse, Audits, Reporting and Record Retention.

- Facility Claims billed on a UB-04 Claim form are excluded from the LMP requirement.
- Molina realizes this information may not always be available to a radiologist or laboratory, particularly for services not performed face-to-face with the Member or the Provider who delivers the baby, especially if the Member received prenatal care from another Provider/facility. To avoid any unnecessary Claim denials, radiologists and laboratories must

ensure the written order or requisition from the treating practitioner includes an LMP date, when applicable. Please remember that participating Providers may estimate the LMP date on delivery Claims based on the gestational age of the child at birth.

Find additional information in the ODM Hospital Billing Guidelines. For EDI Claims, please reference the appropriate ODM Companion Guide (837P/837I), found on the ODM Trading Partner website at medicaid.ohio.gov, for the appropriate loop and segments.

Prenatal Risk Assessment Form (PRAF) requirement

Molina will reimburse Providers for a prenatal risk assessment form (PRAF) by billing HCPCS code H1000 + 33 modifier and completing the appropriate PRAF. The PRAF is a checklist of medical and social assistance needs used as a guideline to determine when a patient is at risk of preterm birth or poor pregnancy outcome. The PRAF is submitted electronically on the NurtureOhio site. It should be filled out for every pregnant member at the initial antepartum visit and during pregnancy when needs have changed. All PRAFs billed correctly will be paid at the code rate.

Forms are available at MolinaHealthcare.com/OhioProviders.

Providers may submit the PRAF to ODM via the NurtureOhio website. For additional information, visit the "Pregnancy Risk Assessment" page at medicaid.ohio.gov.

Childbirth Delivery Procedures and ICD-10 Diagnosis Codes Required on Claims for Mother's Weeks of Gestation of Pregnancy

Providers must include one of the ICD-10 diagnosis codes indicating the mother's weeks of gestation on Claims submitted to the Ohio Department of Medicaid (ODM) and Medicaid Managed Care Organizations (MCO). Find additional information in the ODM Hospital Billing Guidelines.

Well Care through the Perinatal Period

Consider providing an annual well exam for your patients in addition to prenatal or postpartum care. The services required for a well exam (health and developmental history, both physical and mental, a physical exam, and health education/anticipatory guidance) are often provided as part of the prenatal or postpartum exam but may not have been coded in the past.

- Preventive services may be rendered on visits other than specific well-care visits, regardless of the primary intent of the visit.
- Well visit and postpartum visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

Newborn Claims

Molina requires Providers to report the birth weight on all newborn institutional Claims. The appropriate value code must be used to report this data. :

Additional information is available at:
- UB-04: ODM Hospital Billing Guidelines
- 837: Report birth weight as a monetary amount. Reference the appropriate ODM Companion Guide (837I), found on the Billing page at medicaid.ohio.gov, for the appropriate loop and segments.

Obstetrical Care

Molina is committed to promoting primary preventive care for Members. In an effort to ensure that female Members receive all needed preventive care, Molina encourages OB/GYNs to provide preventive care services in conjunction with obstetrical/gynecological visits.

When providing care to Molina Members, consider performing an annual well exam in addition to obstetric/gynecological services.

Services required during a well exam that should be documented in the medical record are:
- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

Note:
- Preventive services may be rendered on visits other than well care visits, regardless of the primary intent of the visit.
- The appropriate diagnosis and procedure codes must be billed to support each service.
- A well exam and an ill visit can be paid for the same office visit, provided that the appropriate procedure and diagnosis codes are included for both services.

Sterilization/Delivery Services

Pursuant to OAC 5160-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy, Claims received for sterilization services are paid only if the required criteria are met, and the appropriate Consent for Sterilization Form (HHS-687) has been received.

Sterilization Claims received without a valid consent form attached that includes services unrelated to the sterilization, i.e., delivery services, will be processed as follows:
- Inpatient hospital Claims on a UB-04 will be denied. Reimbursement can be made for charges unrelated to the sterilization procedure when a corrected Claim is received, removing all of the sterilization-related charges and ICD-10 diagnosis/procedure codes.

- Outpatient hospital Claims on a UB-04 will be denied. Physician services on the HCFA-1500 Claim form will deny the line items for the sterilization services and process the line items unrelated to the sterilization services for payment.

National Drug Codes (NDC)

NDCs are codes assigned to each drug package. Each NDC is an 11-digit number, sometimes including dashes in the format (e.g., 55555-4444-22). They specifically identify the manufacturer, product, and package size.

In accordance with ODM Billing Guidelines, a valid 11-digit NDC number is required to be billed at the detail level when a Claim is submitted with a CPT/HCPCS code that represents a drug. Federal law requires that any code for a drug covered by Medicaid must be submitted with the NDC.

Find additional information in the Medicare Claims Processing Manual 100-04, Chapter 26: Completing and Processing Form CMS-1500 Data Set.

Electronic Claims

For EDI Claims, please reference the appropriate ODM Companion Guide (837I/837P), found on the ODM Trading Partner website at medicaid.ohio.gov, for the appropriate loop and segments. For direct data entry claims, please reference the Availity Essentials portal information in this Provider Manual.

National Provider Identification Number (NPI)

Molina requires all Claims and encounters to include an NPI in all Claim fields that require Provider identification, as provided below, to avoid any unnecessary Claim rejections.

- In accordance with 5010 requirements, NPIs are mandated on all electronic transactions per HIPAA.

If you do not have an NPI, please visit nppes.cms.hhs.gov to obtain an NPI. Any changes to an NPI should also be reported in the ODM PNM system and to Molina within 30 days of the change.

Find additional information:

- Medicare Claims Processing Manual 100-04, Chapter 26: Completing and Processing Form CMS-1500 Data Set
- Molina recommends all Providers reference the appropriate ODM Companion Guide (837I/837P) found on the ODM Trading Partner website at medicaid.ohio.gov for the appropriate loop and segments to ensure all 5010 requirements are being met.

Payment Policy for Services without a Published Reimbursement Rate

Reimbursement for services that are listed without a published rate in the Medicaid Fee Schedule appendices or specified as set forth in an OAC and deemed Medically Necessary is made in accordance with the Provider contract. When the contract is silent, the payment amount is based on the default 30 percent of the billed charge. Providers must bill their usual and customary charges.

- See OAC 5160-2-75 Outpatient Hospital Reimbursement for a list of procedure codes that were deemed inpatient only by the Centers for Medicare and Medicaid Services (CMS) and removed from Appendix C.

Interpreters Statement (Optional)

1. Optional – The interpreter defines the language used in the interpretation.
2. Optional – The interpreter signs their name.
3. Optional – The interpreter enters the date they read the statement to the patient.

Unlisted Codes

Molina encourages Providers to bill with the most accurate and specific CPT or HCPCS code. If an unlisted code is used, documentation is required for all unlisted codes submitted for reimbursement. Documentation should include, but is not limited to:

- A complete description of the unlisted code
- Procedure/operative report for unlisted surgical/procedure code
- Invoice for unlisted DME/supply codes
- NDC number, dose, and route of administration for the drug billed

Documentation will be reviewed for appropriate coding and the existence of a more appropriate code. Claims submitted with unlisted codes that do not have documentation with them and no prior authorization on file will be denied.

Surgical Professional Services

In accordance with OAC 5160-4-22 Surgical Services, physicians must bill using the most comprehensive surgical procedure code(s). This means a Provider should report comprehensive surgical services on a Claim; they are not to itemize or “unbundle” individual components.

Surgical codes subject to multiple surgery pricing are indicated in OAC 5160-4-22 Surgical Services - Appendix. Multiple surgery pricing will apply to the procedures indicated with an "x" in the corresponding column titled “Multiple Surgery” when multiple surgical procedures are performed on the same patient by the same Provider on the same day. These codes should not be billed with multiple units. Billing with more than one unit will result in a denial of that line.

Co-surgery procedures, for which payment is split among two surgeons when performed on a surgical procedure that requires the skill of two surgeons, will be reimbursed based on the amount specified in rule OAC 5160-4-22 Surgical Services or in appendix DD to that rule.

Assistant-at-surgery services performed by Physician Assistants or Advanced Practice Nurses are reimbursed based on the amount specified in rule OAC 5160-4-22 Surgical Services or in appendix DD to that rule.

Transplants

In accordance with OAC 5160-2-03 Conditions and Limitations, services related to covered organ donations are reimbursable when the recipient of a transplant is Medicaid-eligible.

Transplant services will be reimbursed according to the ODM Hospital Billing Guidelines.

Nursing Facilities (NF)

Molina follows ODM billing guidelines for skilled and custodial levels of care. Find additional information in the ODM Hospital Billing Guidelines.

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management, including medication administration, and the delivery of part-time, intermittent nursing, and skilled nursing up to the maximum allowed in OAC 3701-16-09 Personal Care Services; Medication Administration; Resident Medications; Application of Dressings; Supervision of Therapeutic Diets when not available through a third party.

Skilled therapy (physical therapy, occupational therapy, speech-language pathology services, and audiology services) are considered non-institutional professional services furnished by skilled therapists and skilled therapist assistants or aids based on OAC 5160-8-35 Skilled Therapy Services.

The scope of the service does not include 24-hour skilled care, one-on-one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications, or over-the-counter medications.

Hospice Services

Providers are required to bill hospice services on a CMS-1500 form. Providers will need to follow all CMS-1500 rules.

Find additional information in:

- OAC 5160-56-06 Hospice Services Reimbursement, including information on Routine Hospice Tiered Pricing

- Medicare Claims Processing Manual 100-04, Chapter 26: Completing and Processing Form CMS-1500 Data Set

Hospice Room and Board Services

- When a Molina Member resides in a nursing facility (NF) and is receiving services from a hospice Provider, the hospice Provider must bill Medicaid MCOs for room and board. The plans will be required to pay room and board payments directly to the hospice Provider for services rendered versus the nursing facility.
- Molina will reimburse the facility per diem rate in accordance with OAC 5160-56-06 Hospice Services Reimbursement

DME Pricing/Invoice Pricing

Payment for durable medical equipment (DME) – including custom wheelchairs, power wheelchairs, and all wheelchair parts and accessories – as well as medical supplies, orthotics or prosthetics, is reimbursed using the following:

- OAC 5160-10-01 Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS): general provisions, including Appendix
- OAC 5160-60 Medicaid Payment, including Appendix DD

The "invoice price" is defined as the price delivered to the consumer and reflects the Provider's net costs in accordance with OAC 5160-10-01 Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS): general provisions. The invoice price cannot be obscured or deleted on any documentation supplied for consideration of reimbursement. Documentation submitted to support this price is subject to approval by the department.

Wheelchair Repairs

Molina follows the DME guidelines as referenced in the Ohio Department of Medicaid Durable Medical Equipment, Prosthesis, Orthoses, and Supplies. It is imperative that appropriate billing be used to identify the services provided and process Claims accurately.

- OAC 5160-10-01 – Appendix DD, Medicaid Supply List
- Follow Molina PA requirements, available via the PA LookUp Tool
- OAC 5160-10-16 DMEPOS: Wheelchairs, including power-operated vehicles (POVs).
- OAC 5160-10-02 Repair of Medical Equipment

I. Modifiers: HIPAA Compliant Modifiers That Impact Claims Payment

For a complete list of modifiers, please refer to the HCPCS/CPT books or EncoderPro online. Additional information is available in the ODM Modifiers recognized by ODM document.

Ambulance Modifiers signifying to or from a Nursing Facility (NF)

In accordance with OAC 5160-3-19 Nursing Facilities (NFs): Relationship of NF Services to Other Covered Medicaid Services, payment is made directly to the transportation supplier in accordance with Chapter 5160-15 of the Administrative Code. Transportation of residents to receive medical services when the resident does not require an ambulance or wheelchair van is paid through the NF per diem.

- Ohio Administrative Code (OAC) 5160-15 Medical Transportation Services
- OAC 5160-3-19 Nursing Facilities (NFs): Relationship of NF Services to Other Covered Medicaid Services

Anesthesia Service Modifiers

- Ohio Administrative Code (OAC) 5160-4-21 Physician Services: Anesthesia Services

Behavioral Health Service Modifiers

- OAC 5160-8-05 Behavioral Health Services – Other Licensed Professionals
- ODM Behavioral Health Provider Manual

Durable Medical Equipment (DME) Modifiers

- ODM Modifiers recognized by ODM

Home Health Modifiers

- OAC 5160-1-39 Verification of Home Care Service Provision to Home Care Dependent Adults
- OAC 5160-12-04 Home Health and Private Duty Nursing: Visit Policy
- OAC 5160-12-05 Reimbursement: Home Health Services
- OAC 5160-12-06 Reimbursement: Private Duty Nursing Services

Additional Modifiers

- Look for additional modifiers in the ODM Modifiers recognized by ODM document.

J. Type of Bill Codes

Type of Bill codes are available in Medicare Claims Processing Manual 100-04, Chapter 26: Completing and Processing Form CMS-1500 Data Set.

K. Claim Form Requirements

Providers should follow standard guidance for accurate completion of CMS HCFA 1500 and UB-04 claims prior to submission.

VII. Utilization Management

Health Care Services is comprised of Utilization Management (UM) and Care Coordination (CC) Departments that work together to achieve an integrated approach to coordinating care. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care coordination services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services.

Communication and Availability to Members and Providers

Healthcare Services staff are available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 322-4079, Monday through Friday (except for state and federal holidays) from 8 a.m. to 6 p.m. All staff members identify themselves by providing their first name, job title and organization.

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

Providers should use the Availity Essentials portal for UM access.

Molina's 24-hour Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (855) 895-9986. Molina's 24-hour Nurse Advice Line handles urgent and emergent after-hours UM calls.

Utilization Management (UM)

The Molina Utilization Management program provides pre-service authorization, inpatient authorization management, and concurrent review of inpatient and continuing services. Molina aims to ensure that services are medically necessary and an appropriate use of resources for the Member. Some of the elements of the UM program are:

- Evaluating the Medical Necessity and efficiency of health care services across the continuum of care.
- Applying appropriate criteria based on CMS guidelines and, when applicable, state requirements.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Providing pre-admission, admission, and inpatient hospital and SNF review.

- Ensuring that services are available in a timely manner, in appropriate settings and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring that qualified health care professionals are engaged in the UM decision-making process when appropriate.
- Ensuring the appropriate application of Member benefit coverage and coverage criteria.
- For dual eligible Members:
  - Molina will coordinate benefits for dual-eligible members, where applicable, in circumstances where the requested services are not covered by Medicare but are covered by their Medicaid benefit.

Key Functions of the UM Program

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

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

For more information about Molina's UM program or to obtain a copy of the HCS Program description, clinical criteria used for decision making, and how to contact a UM reviewer access the Molina website or contact the UM Department.

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

Primary Care Providers

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

Referrals to specialty care outside the network require prior authorization from Molina. Molina will assist in ensuring access for second opinions from network and out-of-network Providers as well, as applicable.

Avoiding Conflict of Interest

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

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

A. Services that Require Prior Authorization (PA)

Prior Authorization (PA) Code Lookup Tool

Molina requires Prior Authorization (PA) for specified services as long as the requirement complies with federal or state regulations and the Molina Hospital or Provider Services Agreement. The list of services that require Prior Authorization is available in narrative form, along with a more detailed list of CPT and HCPCS codes. Molina Prior Authorization changes documents are customarily updated quarterly but may be updated more frequently as appropriate and are posted on the Molina website at MolinaHealthcare.com/OhioProviders.

Providers are encouraged to use the Molina Prior Authorization Form provided on the Molina web site. If using a different form, the Prior Authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the Medical Necessity of the requested service is required, including:

- Pertinent medical history (include treatment, diagnostic tests, examination data).
- Requested length of stay (for inpatient requests).
- Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the Prior Authorization requirements. 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.

Molina follows all Prior Authorization requirements related to care for newborns and their mothers in alignment with the Newborns' and Mothers' Health Protection Act (NMHPA).

For additional information, please refer to the Prior Authorization tools located on the MolinaHealthcare.com website:

- Prior Authorization Code Lookup Tool.
- Prior Authorization Guide.

Prospective/Pre-Service Review

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

- Member eligibility.
- Member covered benefits.
- The service is not experimental or investigational in nature.
- The service meets Medical Necessity criteria (according to accepted, nationally-recognized resources).
- All Covered Services (e.g., test, procedure) are within the Provider's scope of practice.
- The requested Provider can provide the service in a timely manner.
- The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition.
- The requested Covered Service is directed to the most appropriate contracted specialist, facility, or vendor.
- The service is provided at the appropriate level of care in the appropriate facility, e.g., outpatient versus inpatient or at the appropriate level of inpatient care.
- Continuity and coordination of care are maintained.

- The PCP is kept apprised of service requests and of the service provided to the Member by other Providers.

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina and are **never delegated**:

1. **Transplant -** Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department (Transplant Unit) when the need for a transplant evaluation is identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts Medical Necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. **Clinical Trials -** Molina does not delegate to Providers the authority to authorize payment for services associated with clinical trials. See Clinical Trials below for additional information.
3. **Experimental and Investigational Reviews -** Molina does not delegate to Providers the authority to determine and authorize experimental and investigational reviews.

Clinical Trials

National Coverage Determination (NCD) 310.1 provides that Medicare covers the routine costs of qualifying clinical trials (as defined in the NCD) as well as reasonable and necessary items, and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicare rules apply. Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries that are provided in either the experimental or control arm of a clinical trial except:

- The investigational item or service itself unless otherwise covered outside of the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the clinical trial.

Routine costs in clinical trials include:

- Items or services that are typically provided absent a clinical trial;
- Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, and in particular for the diagnosis or treatment of complications.

For non-covered items and services, including items and services for which Medicare payment is statutorily prohibited, Medicare only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated to reasonable and necessary care. However, if the item or service is not covered by virtue of a national non-coverage policy (i.e., an NCD) and is the focus of a qualifying clinical trial, the routine costs of the clinical trial will be covered by Medicare but the noncovered item or service itself will not.

Clinical trials must meet qualifying requirements. Additional information on these requirements and the qualifying process can be found in NCD 310.1.
If the Member participates in an unapproved study, the Member will be liable for all costs associated with participation in that study. Members can obtain additional information about coverage for the costs associated with clinical trials and Member liability for Medicare cost-sharing amounts in their Member Handbook.

Inpatient Admission Notification and Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility (i.e., including hospitals, SNFs, and other inpatient settings). Contracted SNFs, long-term acute care hospitals (LTACHs), and acute inpatient rehabilitation (AIR) facilities/units must obtain prior authorization before admitting the Member.

Inpatient facilities are also required to notify Molina of the admission within 24 hours or by the following business day or as otherwise specified in the relevant Provider Agreement. Inpatient notifications must be submitted via the Availity Essentials portal, however contact telephone numbers are provided in the Requesting Prior Authorization section of this Provider Manual.

Continued stay must be supported by clinical documentation supporting the level of care. Failure to obtain prior authorization, to provide timely notice of admission, or to support the level of care may result in denial with Provider liability. Members cannot be held liable for failure of a contracted Provider to follow the terms of the relevant Provider Agreement and this Provider Manual. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day or as otherwise specified in the relevant Provider Agreement. Notification of admission is required to verify eligibility, authorize care, including level of care, and initiate concurrent review and discharge planning. Notification must include Member demographic information, facility information, date of admission, and clinical information supporting the level of care. Notifications should be submitted via the Availity Essentials portal,

however contact telephone numbers and fax numbers are noted in the Requesting Prior Authorization section of this Provider Manual.

Prior authorization is not required for an observation level of care. Once the Member is stabilized and a request for inpatient admission is made or the observation period expires, contracted Providers are responsible for supporting an admission level of care. Failure to provide timely notice of admission or to support an admission level of care may result in a clinical level of care denial with Provider liability. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement and this Provider Manual. For additional information on the contracted Provider Claim appeal process please refer to the Claim Dispute/Reconsideration section located in the Claims and Compensation section of this Provider Manual.

Inpatient at Time of Termination of Coverage

Members hospitalized on the day that the Member in the Molina plan terminates are usually covered through discharge. Specific Molina plan rules and Provider Agreement provisions may apply.

NOTICE Act

Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the beneficiary that they are an outpatient receiving observation services and not a hospital inpatient. The beneficiary is informed that their services are covered under Part B and that Part B cost-sharing amounts apply. Additional information is provided to the beneficiary with regard to how an observation stay may affect their eligibility for a SNF level of care and that Part B does not cover self-administered drugs.

Inpatient Concurrent Review

Molina performs concurrent inpatient review to ensure Medical Necessity of ongoing inpatient services, adequate progress of treatment, and development of appropriate discharge plans. Concurrent review is performed for inpatient stays regardless of setting (i.e., including hospital, SNF, and other inpatient setting), although the cadence and extent of concurrent review may vary depending on the setting and the Member's circumstances. Performing these functions requires timely clinical. Molina will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Requested clinical updates must be received from the inpatient facility within 24 hours of the request or such other time as may be indicated in the request.

Failure to provide timely clinical updates may result in denial of authorization for the remainder of the inpatient admission with Provider liability dependent on the circumstances and the terms of the relevant Provider Agreement. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement or this Provider Manual.

Molina will authorize hospital care as an inpatient when the clinical record supports the Medical Necessity of continued hospital stay. An observation level of care should be provided first when appropriate. Upon discharge, the Provider must provide Molina with a copy of the Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. UM staff work to communicate with hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review Medical Necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), SNF, and rehabilitative services.

Readmissions

Readmission review is important to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge and it is determined that the subsequent readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

View the Readmission Payment Policy under the "Policies" page of our Provider Website.

Out-of-Network Providers and Services

Molina maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process. Molina requires Members to receive non-emergency medical care within the participating, contracted network of Providers. Services provided by non-contracted Providers must be prior authorized. Exceptions include Emergency Services and Medically Necessary dialysis services obtained by the Member when they are

outside the service area. Please refer to the section on Emergency Services, Urgent Care, and Post-Stabilization Services above. When no exception applies, Molina will determine whether there are contracted Providers within the service area willing and able to provide the items or services requested for the Member.

B. Prior Authorization Submission Process and Format

Requesting Prior Authorization

Contracted Providers are responsible for requesting prior authorization of services when required by Molina policy, which may change from time to time. Failure to obtain prior authorization before rendering a service may result in a denial with Provider liability and/or denial of the Claim. The Member cannot be billed when a contracted Provider fails to follow the UM requirements for the Molina plan, including failure to obtain prior authorization before the Member receives the item or service. 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 follows a hierarchy of Medical Necessity decision making with federal and state regulations taking precedence. Molina covers all services and items required by state and federal regulations.

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

Requests for authorization not meeting criteria are reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician or pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify or deny payment of services to a Member. Molina's use and interpretation of the American Society of Addiction Medicine's ASAM Criteria for Addictive, Substance-Related, and Co-Occurring Conditions does not imply that the American Society of Addiction Medicine has either participated in or concurs with the disposition of a claim for benefits.

Where applicable, Molina Clinical Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Molina requires prior authorization for specified services. The list of services that require prior authorization is available in narrative form. Molina posts a PA Code Change document quarterly, but it may be updated more frequently. It is posted on the Molina Provider Website

at MolinaHealthcare.com. The Prior Auth Lookup Tool is also available in the Molina Availity Essentials portal.

Providers are encouraged to use the Molina Prior Authorization Request Form provided on the Molina Provider Website at MolinaHealthcare.com. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number, health plan).
- Provider demographic information (ordering Provider, servicing Provider, and referring Provider (when appropriate).
- Relevant Member diagnoses and ICD-10 codes.
- Requested items and/or services, including all appropriate CPT® and HCPCS codes.
- Location where services will be performed (when relevant).
- Supporting clinical information demonstrating Medical Necessity under Medicare guidelines (and/or state guidelines when applicable).

CPT® is a registered trademark of the American Medical Association (AMA).

Members and their authorized representatives may also request prior authorization of any item or service they want to receive. In this case, the physician or other appropriate Provider will be contacted to confirm the need for and specific details of the request.

Contracted Providers are expected to cooperate with Molina UM processes and guidelines, including submission of sufficient clinical information to support the Medical Necessity, level of care, and/or site of service of the items, and/or services requested. Contracted Providers must also respond timely and completely to requests for additional information. If Molina determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Contract or the Provider Manual, a denial may be issued with Provider liability. Members cannot be held responsible when the Provider fails to follow the terms and conditions of the relevant Provider Agreement or this Provider Manual. For information on the contracted Provider Claims appeals process see the Claim Reconsideration subsection located in the Claims and Compensation section of this Provider Manual.

Requests for prior authorization must be sent via EDI or the Availity Essentials portal.

Availity Essentials portal: Molina is transitioning to a portal-only submission model as of Jan. 1, 2026. Providers are to use the Availity Essentials portal for prior authorization submissions. All prior authorization submissions must include supporting clinical documentation to ensure timely and accurate review. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. Molina is dedicated to supporting providers through this transition by offering training and maintaining an exception process for those with documented barriers.

The benefits of submitting your prior authorization request through the Availity portal are:

- Create and submit prior authorization requests electronically
- Check status of prior authorization requests
- Receive notification of change in status of prior authorization requests
- Attach medical documentation required for timely medical review and decision-making
- Receive notification of authorization decisions
- Access prior authorization letters directly through the new DC Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.

Molina has also partnered with MCG Health, to extend the Cite AutoAuth self-service method for all lines of business to submit advanced imaging PA requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission is the primary submission route for advanced imaging requests. Molina will also be rolling out additional services throughout the year. Clinical information submitted with the PA will be reviewed by Molina. This system will provide quicker and more efficient processing of authorization requests and the status of the authorization will be available immediately upon completion of its submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to MRIs, CTs, PET scans. For a full list of imaging codes that require PA, refer to the PA code Look-Up Tool.

MCG Cite Guideline Transparency
Molina has partnered with MCG Health to implement Cite Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite Guideline Transparency, Molina can share clinical indications with Providers. The tool operates as a secure extension of Molina's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency – Delivers medical determination transparency.
- Access – Clinical evidence that payers use to support member care decisions.
- Security – Ensures easy and flexible access via secure web access.

MCG Cite Guideline Transparency does not affect the process for notifying Molina of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina's Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (855) 895-9986. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. PCPs are notified via fax of all Nurse Advice Line encounters.

Notwithstanding any provision in the Provider's Agreement with Molina that requires a Provider to obtain a prior authorization directly from Molina, 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 Auth Look-Up Tool located on the MolinaHealthcare.com website.

Communication of Pre-Service Determinations

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone, fax or via the Availity Essentials portal.

When a pre-authorization request is denied with Member liability, the Member is issued a denial notice informing them of the decision, as well as the option to request a peer-to-peer consultation, their appeal rights and external medical review. The Member's appeal rights are discussed further in the Appeals and Grievances section of this Provider Manual.

When a pre-authorization request is denied with Provider liability, the Provider is issued a denial notice informing them of the decision. Additional information on the contracted Provider Claims appeal process can be found in the Claim Reconsideration subsection found in the Claims and Compensation section of this Provider Manual.

Providers may receive notifications or denials via fax or the Availity portal**.**

C. Timeframes for Responding to Standard and Expedited Prior Authorization Requests

Timeframes

Prior authorization decisions are made as expeditiously as the Member's health condition requires and within regulatory timeframes per OAC rule 5160-58-03.1 and ORC 5160.34.

- Expedited Initial requests must be made as soon as medically necessary, within 48 hours (including weekends and holidays) following receipt of the validated request.
- Standard requests must be made as soon as medically indicated, within a maximum of 7 calendar days after receipt of request.

Medicare organization and coverage determination time frames for pre-service requests are:

Expedited (non-Part B, non-Part D drug)	*72 hours – Medicare guidance allows written notice to follow within 3 calendar days after verbal notice to the member
Expedited Part B drug	24 hours
Expedited Part D drug	24 hours
Standard (non-Part B, non-Part D drug)	* 7 calendar days
Standard Part B drug	72 hours
Standard Part D drug	72 hours

**Timeframes for fully integrated plans may vary with regulatory and contractual requirements.*

Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).

A Provider may request that a UM decision be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that a request be expedited only when this standard is supported by the Member's condition. Vendors are not allowed to expedite without a physician order stating it needs expedited time frame.

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

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review, or retrospectively. Medical Necessity decisions are made by a physician or other appropriate licensed health care personnel with sufficient medical expertise and knowledge of the appropriate coverage criteria. These medical professionals conduct Medical Necessity reviews in accordance with CMS guidelines (such as national and local coverage determinations) and use nationally recognized evidence based guidelines, third party guidelines, guidelines from recognized professional societies, and peer reviewed medical literature, when appropriate. Providers may request to review the criteria used to make the final decision by contacting Molina or utilizing the above-referenced MCG Cite for Care tool.

Where applicable, Molina Clinical Policies can be found on the Provider Website. Please note that Molina follows federal/state specific criteria, if available, before applying Molina-specific criteria.

Clinical Information

Molina requires copies of clinical information to be submitted for documentation. Clinical information includes but is not limited to physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations, and therapist notes. Molina does not accept clinical summaries, telephone summaries, or inpatient Care Manager criteria reviews as meeting the clinical information requirements unless state or federal regulations allow such documentation to be accepted.

Requests should be submitted via the Availity Essentials portal.

Open Communication About Treatment

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

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

Affirmative Statement about Incentives

Health care professionals involved in the UM decision-making process base their decisions on the appropriateness of care and services and the existence of coverage. Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care and does not provide financial incentives or other types of compensation to encourage decisions that result in under-utilization or barriers to care.

D. Provider Procedures

1. Peer-to-Peer Consultations

Providers may request a peer-to-peer consultation when the MCOP denies a prior authorization request. The peer-to-peer consultations will be conducted amongst health care professionals who have clinical expertise in treating the member's condition, with the equivalent or higher credentials as the requesting/ordering provider. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item,

procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines.

Adverse decisions for which only Provider liability is assigned and that do not involve an adverse determination or liability for the Member may be subject to a peer-to-peer conversation. A peer-to-peer conversation is an opportunity to clarify the clinical information or to provide newly discovered clinical information.

Molina will not allow contracted Providers to use the peer-to-peer process as a vehicle for routine failure to provide sufficient information in the UM process or to avoid the contracted Provider Claims appeals process. Contracted Providers are responsible for providing all information to support the request within the required timeframes. Additional information on the contracted Provider Claims appeals process can be found in the Claim Reconsideration subsection found in the Provider Claims Dispute Resolution Process section of this Provider Manual.
A "peer" is considered a physician, physician assistant, nurse practitioner, or PhD psychologist who is directly providing care to the Member or a Medical Director on site at the facility. Calls from EHR and other similar contracted external parties, administrators, or facility UM staff are not peers and calls will not be returned.

To make the Peer-to-Peer request **within 5 calendar days of the denial notice or up to the date of discharge for inpatient services**:

- Call Molina Healthcare Utilization Management at (855) 322-4079 from 8 a.m. to 8 p.m., Monday to Friday.
- Include two possible dates and times a licensed professional is available to conduct the review with a Molina medical director.

2. Provider Appeals (Authorization Appeals)

The Provider can request an Authorization Appeal of a Prior Authorization denial.

Providers may request a provider appeal if the MCOP denies a prior authorization request in accordance with ORC 5160.34. The provider appeal is separate from the peer-to-peer or member appeal processes. Provider appeals will be responded to within forty-eight hours for urgent care services and within ten calendar days for all other matters.

See directly below for application of these noted timeframes.

- **Authorization Appeal (Pre-Claim):** Formerly known as an "authorization reconsideration." A Provider dispute for the denial of a Prior Authorization. An Authorization Appeal can be faxed within 60 calendar days of the date on the authorization denial or until the Claim is received. The Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form) can be found at MolinaHealthcare.com/OhioProviders. For

additional information, view the Medicaid and MyCare Ohio Authorization Appeal and Clinical and Non-Clinical Claim Dispute Guide, which is available on our website under the "Manual" tab. Pre-Claim Authorization Appeals cannot be submitted via the portal. Authorization Appeals will be responded to within forty-eight hours for urgent care services and within ten calendar days for all other requests. Once the Claim is on file, Providers must follow the **Clinical Claim Dispute** process.

- **Clinical Claim Dispute (Post-Claim):** A Clinical Claim Dispute can be submitted via the Availity Essentials portal or faxed within 365 calendar days of the date of service or within 60 days of the remittance date; whichever is greater. The Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form) required for submission can be found at MolinaHealthcare.com/OhioProviders. For additional information, view the MyCare Ohio Authorization Appeal and Clinical and Non-Clinical Claim Reconsideration Dispute Guide available on our Provider Website under the "Manual" tab. If submitting via the portal, the submission will take place under "Appeals" in the "Payer Spaces" section.

See VIII. Claims Information for more information about the Provider Appeals process.

See VI. Covered Services "Member Appeals" section for more information about provider supported member appeals, form and process. The member appeal process is separate from the provider appeals process.

Note: If the provider utilizes the provider appeal form and includes the member consent, this submission will be considered a provider appeal and not converted into a member appeal. A member appeal must include the member appeal for and member consent.

3. External Medical Review

External Medical Review

The review process conducted by an independent, external medical review (EMR) entity that is initiated by a provider who disagrees with a MCOP's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. MCOPs are required to notify providers of their option to request an EMR as part of any medical necessity denial.

Currently, the EMR will be conducted by Permedion. This vendor has a contract with ODM to complete the third-party medical review.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCOP's internal provider appeal or claim dispute resolution process. Failure to exhaust the MCOP's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

An EMR can be requested by a provider as a result of:

- An MCOP's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity; or
- An MCOP's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity.

Denials, limitations, reductions, suspensions, or terminations based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent, and retrospective reviews).
- Clinical judgement or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC rule 5160-1-01 and/or the MCOP's clinical coverage or utilization management policy or policies) is not met.

Requesting an External Medical Review

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at www.hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from MCOP (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.
- Providers may submit new or other relevant documentation as part of the EMR request.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at https://ecenter.hmsy.com/ (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access).

If the MCOP determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with the provider's right to request a peer-to-peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions.

Once the provider has submitted the EMR request, they do not need to take further action.

Completing the External Medical Review

After the EMR request has been submitted, Permedion will share any documentation from the provider with the MCOP. Following its review of this information the MCOP may reverse its denial, in part or in whole. If the MCOP reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify the EMR entity. If the MCOP decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.

- If the decision reverses the MCOP's coverage decision in part or as a whole, that decision is final and binding on the MCOP.
- If the decision agrees with the MCOP's decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, the MCOP must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCOP receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the MCOP must pay for the disputed services within the timeframes established for claims payment in Appendix L of the MyCare Ohio Provider Agreement.

For more information about the EMR, please contact Permedion at 1-800-473-0802, and select Option 2.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. These entities are required to perform these functions in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

E. Termination of Ongoing Services

Termination of Inpatient Hospital Services

Hospitals are required by CMS regulations to deliver the Important Message (IM) from Medicare (IM, Form CMS-10065), to all Medicare beneficiaries (including Medicare Advantage enrollees) who are hospital inpatients within two calendar days of admission. This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery must be made to

the Member or the Member's authorized representative in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than two calendar days before the planned discharge date.

The IM informs beneficiaries of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines and must obtain the signature of the beneficiary or their representative and provide a copy at that time. When the Member is no longer meeting criteria for continued inpatient stay and the hospital has not initiated discharge planning, Molina may require that the hospital issue a follow-up copy of the IM and notify the Member of their discharge date or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with Provider liability. The Member cannot be held liable for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located within the IM and if the Member exercises their appeal rights, not until noon of the day after the Quality Improvement Organization (QIO) notifies the Member of a determination adverse to the Member.

When the Member exercises their appeal rights with the QIO, the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the Member as soon as possible and no later than noon follow the day of the QIO's notification to the hospital of the appeal. The hospital is required to provide all information the QIO requires to make its determination. At the Member's request, the hospital must provide the Member a copy of all information provided to the QIO, including written records of any information provided by telephone. This documentation must be provided to the Member no later than close of business of the first day the Member makes the request.

The exhaustion of a Member's covered Part A hospital days is not considered to be a discharge for purposes of issuing the IM.

Termination of SNF, CORF and HHA Services

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Medicare beneficiaries to inform them of the termination of ongoing services (discharge) by a SNF (including hospital swing beds providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA). The NOMNC also provides the beneficiary with their appeal rights for the termination of services. The NOMNC must be delivered to the Member or the Member's authorized representative in accordance with CMS guidelines and at least two calendar days prior to discharge (or the next to the last time services are furnished in the case of CORF or HHA services).

When Molina makes a determination that the Member's continued services are no longer skilled and discharge is appropriate, a valid NOMNC is sent to the contracted Provider (SNF, CORF or HHA) for delivery with a designation of the last covered day. Contracted Providers are

responsible for delivering the NOMNC on behalf of Molina to the Member or Member representative and for obtaining signature(s) in accordance with CMS guidelines. The contracted Provider must provide Molina with a copy of the signed NOMNC. If the Member appeals the discharge to the QIO, the contracted Provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The Member cannot be held liable for any care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located in the NOMNC and if the Member exercises their appeal rights, not before the appeal process with the QIO is complete. If the QIO's decision is favorable to the Member, the Member cannot be held liable until a proper NOMNC is issued and the Member is given their appeal rights again. Failure of the contracted Provider to complete the notification timely and in accordance with CMS guidelines or to provide information timely to the QIO may result in the assignment of Provider liability. Members cannot be held responsible for the contracted Provider's failure to follow the terms of the relevant Provider Agreement or the Provider Manual.

A NOMNC is not issued in the following instances:

- When services are reduced (e.g., when a Member is receiving physical therapy and occupational therapy from a home health agency and only the occupational therapy is terminated);
- When the Member moves to a higher level of care (e.g., from home health to SNF);
- When the Member exhausts their Medicare benefit;
- When the Member terminates services on their own initiative;
- When the Member transfers to another Provider at the same level of care (e.g., a move from one SNF to another while remaining in a Medicare-covered stay); or
- When the Provider terminates services for business reasons (e.g., the Member is receiving home health services but has a dangerous animal on the premises).

VIII. Claims Information

Molina generally follows CMS billing guidelines for Medicare Covered Services and ODM guidelines for non-Medicare Covered Services for the Molina Complete Care for MyCare Ohio plan. Providers will have 365 days to timely file a Claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) Rule 5160-1-19.

Availity Essentials Portal	availity.com/providers/
Clean Claim Timely Filling: MyCare Ohio Medicaid	Unless otherwise agreed upon by ODM, Molina shall accept claims from all provider types for up to 365 calendar days from the date of service.
Clean Claim Timely Filing: Molina Complete Care for MyCare Ohio	• For services that bypass Medicare and Molina processes as the primary payer (MyCare Ohio Medicaid) timely

	filing limit is up to 365 calendar days from the date of service. • When Molina Complete Care for MyCare Ohio processes as the primary payer, the timely filing limit is up to 365 days from the date of service. • Out-of-network: 365 days from the date of service.

1. Electronic Claim Submission

Providers are required to submit MyCare Ohio Claims via OMES EDI transactions or direct data entry claims via the Availity Essentials portal utilizing the Payer ID(s) referenced below.

EDI Payer IDs		
Line of Business	**Payer ID**	**Which Member ID do I bill with?**
Ohio ABD (Medicaid)	0007316	Molina's Medicaid Member ID
Ohio Adult Extension (Medicaid)	0007316	Molina's Medicaid Member ID
Ohio Healthy Families (Medicaid)	0007316	Molina's Medicaid Member ID
SKYGEN Dental: Medicaid	D007316	Molina's Medicaid Member ID
March Vision: Medicaid	V007316	Molina's Medicaid Member ID
Ohio Marketplace Program	20149	Molina's Marketplace Member ID
Ohio Marketplace Program Primary with Ohio Medicaid Secondary (ABD, Adult Extension, Healthy Families)	20149	Molina's Marketplace Member ID
New Plan: Molina Complete Care for MyCare Ohio (HMO D-SNP/FIDE) (Dual Benefits) **for dates of service 1/1/2026 and after.**	0021586	Molina's Medicaid Member ID

EDI Payer IDs		
Line of Business	**Payer ID**	**Which Member ID do I bill with?**
New Plan: Molina MyCare Ohio Medicaid (Medicaid Only) **for dates of service 1/1/2026 and after.**	0021586	Molina's Medicaid Member ID
Legacy Plan: Molina Dual Options MyCare Ohio (HMO D-SNP) (Opt In) **for dates of service 12/31/2025 and prior.**	0021586	Molina's Medicaid Member ID
Legacy Plan: Molina MyCare Ohio Medicaid (Opt Out) **for dates of service 12/31/2025 and prior.**	0021586	Molina's Medicaid Member ID
SKYGEN Dental: Molina Complete Care for MyCare Ohio (HMO D-SNP/FIDE) (Dual Benefits)	D0021586	Molina's Medicaid Member ID
SKYGEN Dental: Molina MyCare Ohio Medicaid (Medicaid Only)	D0021586	Molina's Medicaid Member ID
March Vision: Molina Complete Care for MyCare Ohio (HMO D-SNP/FIDE) (Dual Benefits)	V0021586	Molina's Medicaid Member ID
March Vision: Molina MyCare Ohio Medicaid (Medicaid Only)	V0021586	Molina's Medicaid Member ID
Molina Medicare DSNP (Medicare/MAPD)	20149	Molina's Medicare Member ID

Availity Essentials Portal

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

- Submit Professional (CMS-1500) and Institutional (UB-04) Claims with attached files
- Correct/Void Claims

- Add attachments to new/corrected Claims submissions
- 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
- Manage overpayment invoices (Inquire, Dispute and Resolve)
- Pull a claims report

Availity Essentials Portal: availity.com/providers/

HIPAA 5010 Transaction Compliance Standards Implementation

Molina recommends all Providers reference the appropriate ODM Companion Guide (837I, 837P), found on the ODM Trading Partner website at medicaid.ohio.gov, to ensure all 5010 requirements are being met to avoid any unnecessary Claim rejections. Molina's payer IDs for OMES EDI transactions for MyCare Ohio dates of service before, on, and after Jan. 1, 2026, are noted in this Provider Manual.

A. Process and Requirements for the Submission of Claims

ODM Provider Network Management System Direct Data Entry

- ODM's expectation is that for each Medicaid provider, the MCOP's system, and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM's system of record, MCOPs have been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified between the MCOP's data and the PNM PMF. Molina is instructed by ODM to not accept changes from providers into their own systems that are inconsistent with PNM system data shared through the PNM for their Medicaid line of business.
- Providers may submit eligibility inquiries through the Provider Network Management (PNM) system.
- https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Electronic Data Interchange (EDI) submission of provider claims

- Providers may submit claims, eligibility inquiries, and claim status inquiries using electronic data interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP.
  - https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners

- Providers submitting MyCare claims destined for one of the MCOPs must be submitted through the Ohio Medicaid Enterprise System (OMES) one front door hosted by Deloitte EDI
  - Each file must only contain the claims for the MCOP identified by the Receiver ID
  - Claims must include the appropriate Payer ID in the 2010BB loop so claims are appropriately routed by the receiving MCOP
  - Information on the Receiver ID and 2010BB Payer ID can be found in Section 7 of the ODM Companion Guides found here: https://medicaid.ohio.gov/resources-for-providers/billing/hipaa-5010-implementation/companion-guides/guides

1. Claim Submission

Participating Providers are required to submit Claims with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines. Providers must utilize electronic billing though the ODM Fiscal Intermediary utilizing OMES EDI transactions whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use the correct electronic Payer ID number listed in this Provider Manual.

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.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must update the Provider Network Management (PNM) system as soon as possible, but no less than 30 calendar days in advance of changes, with the exception of atypical Providers only. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

ODM requires rendering practitioner NPI on Claims for:

- Independently licensed behavioral health professionals.
- BH dependently licensed and paraprofessionals.
- Federal Qualified Health Center (FQHC).
- Rural Health Clinic (RHC).
- Occupational Health Facility (OHF).
- Accredited Health Care Clinic (AHCC) clinics.
- Freestanding birth center staff.

ODM fee-for-service requires the NPI of the professionals referenced above to be on the Claim and will deny Claims that do not include the rendering NPI.

Claims submitted without the required NPI will be denied with the exception of claims from Atypical Providers. Atypical providers are not required to obtain an NPI. If the provider has an NPI, it must be submitted on the claim.

2. Ordering, Referring, and Prescribing (ORP) Providers NPI

As of July 1, 2021, Molina requires the billing of Ordering, Referring and Prescribing (ORP) Providers based upon the requirements developed by ODM in compliance with federal regulation 42 CFR 438.602 and 42. CFR 455.410. Claims billed with the attending field information will also be used to satisfy the ORP requirements.

Consistent with these rules, a valid National Provider Identifier (NPI) will be required on claims for select ORP Provider types which are eligible to order, refer or prescribe. For the most current listing of impacted Providers view the Provider Bulletin ORP NPI articles in the Provider Bulletins archived on the Molina Provider Website.

Beginning on Jan. 1, 2026, Molina will reject newly received claims, regardless of the date of service, that lack the appropriate ORP information.

The following information must be included on every Claim:

- Member name, 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, Current Procedural Technology (CPT) or Healthcare Common Procedure Coding System (HCPCS) for services or items provided
- Valid diagnosis pointers
- Total billed charges
- Place and type of service code
- Days or units, as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- 10-digit National Provider Identifier (NPI) of the Billing Provider or Group
- Rendering Provider name as applicable
- Billing/pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NDC Units, Unit of Measure and Days or Units for medical injectables
- Valid 11-digit National Drug Code (NDC) number – required to be billed for HCPCS codes in the J series; HCPCS codes in the Q or S series that represent drugs; CPT codes in the 90281-

90399 series (immune globulins); and Enteral Nutritional B Code Products that price AWP (B4150-B4162)
- E-signature
- Service facility location information
- Other insurance information, as applicable
- HIPAA-compliant CPT, HCPCS and modifier code sets
- Billed charges for each service line
- For prenatal or delivery services, the last menstrual period (LMP) date is required
- Global Delivery Claims need to file documentation of Postpartum visits

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.

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

Report all drugs billed to Molina that were acquired through the 340B drug pricing program spending with an SE modifier, so they can be properly excluded from federal drug rebates. As a reminder, Providers must be certified on the Provider Master File with a valid Medicaid ID and NPI.

3. Paper Claim Submissions

Effective Jan. 1, 2026, MyCare Ohio Providers must submit Claims electronically via the ODM OMES system or the Availity Essentials Portal. Paper Claims are not accepted.

4. Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically through the ODM OMES system or the Availity Essentials portal with the appropriate fields on the 837I or 837P completed.

The Availity Essentials portal includes functionality to submit corrected Institutional and Professional Claims. Corrected Claims must include the correct coding to denote if the Claim is a Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P and include the original Claim number.

5. Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and UB-04 forms.

Corrected Claims must be submitted electronically via EDI or the Availity Essentials portal.

All Corrected Claims:

- The original Claim number must be inserted in the correct field or the applicable 837 transaction loop for submitting corrected Claims electronically. The appropriate frequency code/resubmission code must also be billed on the Claim.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 Claim forms or the Uniform Billing (UB) Editor for UB-04 Claim forms.

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.

Corrected Claims must be sent within 365 calendar days of the most recent adjudicated date of the Claim or the paid claim if one is on file.

Claims submitted without the correct coding will be returned to the Provider for resubmission.

Corrected Claim submissions are not adjustments and should be directed through the original submission process marked as a corrected Claim, as outlined below, or it may result in the Claim being denied. As a reminder: Primary insurance Explanation of Benefits (EOB) and itemized statements are not accepted via Non-Clinical Claim Disputes. Please submit as corrected Claims.

Corrected Claims

Reminders for the Corrected Claims Process:

- Submit electronically.
- Include all elements that need correction, and all originally submitted elements.
- Do not submit only codes edited by Molina.
- Do not submit via the Claim Dispute process.
- Do not submit paper corrected Claims.
- Include the original Molina Claim ID or last paid Claim number.

Attachments

When submitting attachments through the Availity Essentials portal:

- Supported file formats are PDF, TIFF, JPG, BMP and GIF.
- If a file exceeds 640 MB an alert will be sent, and the Claim will not process.

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

Coordination of Benefits (COB)

See the Timely Claim Filing section for filing time frame requirements to Molina.

Coordination of Benefits (COB) – Molina shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan, applicable state and federal laws and applicable CMS guidance. If Molina is the secondary payer due to COB, Providers shall bill primary insurers for items and services they provide to a Member before they submit Claims for the same items or services to Molina for reimbursement. Molina will adjudicate the Claim based upon the primary explanation of benefits (EOB) submitted and pay for covered services up to the secondary liability based upon COB payment guidelines.

Molina offers Provider 270 days from the Claim payment to bill the third party liability. After 270 days Molina may choose to follow the Claim reclamation process.

Providers will not require Members who have a primary carrier to submit secondary Claims to Molina themselves. Per OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements, Providers may not bill Members the difference between the amount a primary carrier paid and the covered amount, even if that balance involves a copayment, coinsurance or plan deductible unless a signed waiver is on file for a non-covered Medicaid service. Should Providers choose not to bill Molina as secondary, the balance due after the primary carrier has paid must be written off by the Provider, which includes any Member copayment, coinsurance and plan deductible.

Molina follows the applicable regulatory guidance associated with COB. These include:

- OAC 3901-8-01 Coordination of Benefits
- OAC 5160-1-05 Medicaid Coordination of Benefits with the Medicare Program (Title XVIII)
- OAC 5160-1-05.1 Payment for Medicare Part C Cost Sharing
- OAC 5160-1-05.3 Payment for Medicare Part B Cost Sharing
- OAC 5160-1-08 Coordination of Benefits
- OAC 5160-2-25 Coordination of Benefits: Hospital Services
- OAC 5160-3-64.1 Nursing Facilities (NFs): Payment for Cost-Sharing Other Than Medicare Part A
- OAC 5160-26-09.1(C): Managed Health Care Programs: Third Party Recovery/Coordination of Benefits

Submitting Updated COB Information

Complete and accurate COB information is necessary for Molina to pay Claims timely and accurately. Molina streamlined the COB process so that it is easier for you to communicate the information with Molina.

If COB information has changed or termed, please call the Molina Provider Services Department at (855) 322-4079 with updated information.

Information to include:

- Molina ID number.
- A front and back copy of the other insurance ID card.
- Verification of eligibility, including the Member ID number and the coverage dates from the other insurance carrier or third party vendor.

Health plans use the ODM Health Insurance Fact Request ODM 06614 available at medicaid.ohio.gov to verify COB information.

Provider Takes Reasonable Measures to Obtain Third Party Payment

Molina shall consider COB Claims for payment when a primary carrier has not processed the Claim in full when reasonable measures to obtain payment have been completed. In accordance with OAC 5160-26-09.1 Managed Health Care Programs: Third Party Liability and Recovery, reasonable measures are defined as follows:

- The Provider first submits a Claim to the primary payer for the rendered service(s) and does not receive a remittance advice or other communication within 90 days after the submission date. The Provider must provide documentation from the primary payer.
- The Provider has retained and/or submitted at least one of the following types of communication that indicates a valid reason, unrelated to Provider error, for non-payment of service(s):
  - Documentation from the primary payer.
  - Documentation from the primary payer's automated eligibility and Claim verification system.
  - Documentation from the primary payer's Member benefits reference guide.
  - Any other information and/or documentation from the primary payer illustrating there is no benefit coverage for the rendered service(s).
  - A screen print from the Provider's billing system.
- The Provider submitted a Claim to the primary payer and received a partial payment, along with a remittance advice, documenting the allocation of the charges.
  - Valid reasons for non-payment from a primary payer to the Provider for a third party benefit Claim include, but are not limited to, the following:
    - The Member does not have benefits through the primary payer for the date of service.

- All the Provider's billed charges or the primary payer's approved rate was applied, in whole or in part, to the Member's benefit deductible amount, coinsurance and/or co-payment.
- The Member has not met any required waiting periods, or residency requirements for their benefits, or was non-compliant with the primary payer's requirements in order to maintain coverage.
- The Member is a dependent of the individual with benefits, but the benefits do not cover the individual's dependents.
- The Member has reached the service(s) not covered under the Member's benefits.
- The lifetime benefit for the medical service or benefits has been met.
- The primary payer is disputing or contesting its liability to pay the Claim or cover the service.

Contractual timely filing provisions still apply.

If payment from the primary carrier is received after Molina has made payment, the Provider is required to repay Molina any overpaid amount. The Provider must not reimburse any overpaid amounts to the consumer.

Consistent with the Deficit Reduction Act of 2005 and the Ohio Administrative Code, Molina has an established process to identify third party liability through review and coordination of benefits (COB). This process may identify and coordinate benefits pre-claim or post-claim payment.

Definition: "Claim Reclamation" describes Molina's billing to a member's commercial third party coverage on behalf of a provider for reimbursement of the primary payment amount paid to the provider by Molina.

Molina offers providers additional time to bill the third party payor with a timeframe of 270 days of claim payment. The below details outline Molina's prior and updated third party liability COB process:

Pre-claim:

Provider receives Molina remittance advice denying the claim for other coverage/primary EOB as noted in the following grid.

Claim remit number	Claim remit message
377	EOB not received on Claim
216	No COB entered with a Secondary Enrollment

Post-claim:

- If Molina identifies commercial third party liability more than 270 days from provider's payment date from Molina for *MyCare Ohio, Medicare, and Marketplace lines of business*:
  - Molina will issue a letter to the provider stating the details of the third party payor identified by Molina as well as a request for refund of the impacted Claims within 60 days.
  - Provider to perform COB and bill the third party payor identified.
  - Provider should refund Molina for the amount paid on the impacted claim(s) within 60 days.
  - If no refund is received from the provider within 60 days, Molina will recover the amount paid from future claim payments.
  - Upon receipt of third party payment, provider should submit the claim and third party remittance to Molina for COB, subject to timely filing requirements.
- If Molina identifies commercial third party liability more than 270 days from provider's payment date from Molina for *Medicaid*:
  - Molina will submit the provider's claim to the third party payor following the Claim Reclamation process.
  - OPT-OUT PROCESS: Providers may choose to opt-out of the Molina Claim Reclamation process. To do so, providers must submit a request to opt-out. The request will include the following elements:
    - Submitted on the provider's letterhead
    - List the specific tax identification number(s) to opt out
    - EMAIL TO: OHProviderRelationsHospital@MolinaHealthcare.com

Risks of opt-out: For providers who opt-out of Claim Reclamation, Molina will recover claim payment via provider refund or recovery from future claim payments. In the event the third party payor denies the provider's claim due to timely filing or lack of medical necessity, Molina will also deny the claim as the secondary payer. Molina will also confirm the provider's claim meets Molina timely filing requirements for any additional payment as the secondary payer.

Coordination of Benefits for Global Obstetrical Claims

If a primary carrier EOB is received with a global obstetrical delivery code, Molina requires an itemized statement showing dates of service and CPT codes for:

- Prenatal visits (Evaluation and Management [E&M] codes – append TH modifier, if appropriate).
- Delivery.
- Postpartum visits.

The payment will be manually calculated to determine secondary payment. Manual calculation is necessary because global OB codes are not an Ohio Medicaid Covered Service. The ODM allowable for each CPT listed on the itemized statement (as long as the Member was covered with Molina at the time of service) will be multiplied by the Provider's contracted rate to

determine what Molina's payment would have been if Molina would have been primary. The primary carrier's payment is subtracted from Molina's calculated allowable.

- If the primary carrier paid more than the Molina allowable, no additional payment will be made.
- If the primary carrier paid less than the Molina allowable, Molina will pay the difference up to Molina's allowable.

MyCare Ohio Third Party Liability (TPL)

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

Ohio Medicaid, Molina Complete Care for MyCare Ohio Secondary and Molina Complete Care for MyCare Ohio Opt-Out Third Party Liability (TPL)

Molina is required to notify ODM and/or its designated agent within 14 calendar days of all requests for the release of financial and medical records to a Member or representative pursuant to the filing of a tort action. Notification must be made via the Notification of Third Party (tort) Request for Release Form (ODM 03245, rev. 7/2014).

Molina must submit a summary of financial information to ODM and/or its designated agent within 30 calendar days of receiving an original authorization to release financial Claim statement letter from ODM pursuant to a tort action. Molina must use the Notification of Third Party (Tort) Request for Release. Upon request, Molina must provide ODM and/or its designated agent with true copies of medical Claims.

Molina is prohibited from accepting any settlement, compromise, judgment, award or recovery of any action or Claim by the enrollee.

Molina will pay Claims for Covered Services when third party benefits are not available. Molina does not recover TPL-related overpayments but will notify the ODM vendor to attempt to recover any third party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

7. Federally Qualified Health Centers (FQHCs) / Rural Health Clinics (RHCs) Wrap-around Payments

The following is Molina's Medicaid Provider number for use when submitting documents for wrap-around payments.

Line of Business – Region:

- Molina Complete Care for MyCare Ohio Plan
  - Molina Medicaid ID Number: 0082414

8. Enhanced Ambulatory Patient Grouping (EAPG) for MyCare Ohio Medicaid

The State of Ohio and all Managed Care Organization (MCO) have adopted version 3.14 of 3M's Enhanced Ambulatory Patient Grouping (EAPG) payment methodology for outpatient hospital Claims.

All hospitals that are subject to Diagnosis Related Group (DRG) prospective payment as described in rule OAC 5160-2-65 Inpatient Hospital Reimbursement and that provide covered outpatient hospital services to eligible Medicaid beneficiaries as defined in rule OAC 5160-2-02 General Provisions: Hospital Services are subject to the payment policies described in this rule. Hospital classifications referred to in this rule and the appendices are described in rule OAC 5160-2-05 Classification of Hospitals.

Hospitals exempt from prospective payment will continue to be paid reasonable costs as described in the Administrative Code OAC 5160-2-22 Non-DRG Prospective Payment for Hospital Services.

9. Hospital-Acquired Conditions (HAC) and Present on Admission Program (POA)

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

The following is a list of CMS Hospital Acquired Conditions. CMS reduced payment for hospitalizations complicated by these categories of conditions that were not Present on Admission:

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

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

What this means to Providers

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

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

10. Community Behavioral Health Services

A complete billing guide, coverage, and other reference documents can be found on the Ohio Department of Medicaid website for Medicaid Behavioral Health at bh.medicaid.ohio.gov/manuals. Please consult the ODM BH Manual for additional details.

Practitioners independently licensed by a professional board are required to be reported using their personal NPI as the rendering practitioner. The ODM BH Manual includes more information on practitioner types.

Practitioner NPIs are required in the rendering field, with the exception of Atypical Providers only. Some modifiers that indicate practitioners continue to be required. Please consult the ODM BH Manual for more information about required practitioner modifiers.

Opioid Treatment Program (OTP)

All the OTP services must be performed by one of the following medical professionals within their scope of practice: physician, physician assistant, clinical nurse specialist, certified nurse practitioner, licensed practical nurse, or registered nurse.

Providers should utilize the following resources when billing for the Methadone Administration for Opioid Treatment Program and Buprenorphine Administration for Opioid Treatment Program:

- ODM Opioid Treatment Program (OTP) Manual
- Molina's Opioid Safety Provider Education Resources

11. Molina Coding Policies and Payment Policies

Frequently requested information on Molina's Coding Policies and Payment Policies is available on the Payment Integrity Policies page of the Provider Website. Questions can be directed to your Provider Relations Team.

View the Molina Clinical Policies at MolinaClinicalPolicy.com. Each policy notes the effective date, as well as any subsequent revision dates and details.

12. Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. 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 that follow 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 Units (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.
- 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.

13. Telehealth Claims and Billing

Providers must follow CMS guidelines as well as the ODM telehealth billing guidelines.

All telehealth Claims for Molina Members must be submitted with correct codes and appropriate modifiers for the plan type and service.

For guidance, please refer to the Telemedicine, Telehealth Services and Virtual Visits policies at:
- Medicare: telehealth.hhs.gov/providers
- Medicaid: OAC 5160-1-18 Telehealth, ODM's Telehealth Services: Guidelines for Managed Care Entities document and Center for Connected Health Policy: cchpca.org/all-telehealth-policies/

14. National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. 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.

15. General Coding Requirements

Correct coding is required to properly process 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 American Medical Association (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.

The following place of service codes are not valid and should not be used.

- 00: Unassigned
- 01: Pharmacy
- 02: Telehealth (Only for Medicare as Primary Payer; POS 02 will be denied for Medicaid as Primary Payer, unless stated otherwise in ODM's telehealth billing guidelines)
- 03: School (Only valid for Medicaid BH services)
- 04: Homeless Shelter
- 05: Indian Health Service – Free-standing facility
- 07: Tribal 638 – Free-standing facility
- 08: Tribal 638 – Provider-based facility
- 09: Unassigned
- 10: Unassigned
- 18: Unassigned
- 27-30: Unassigned
- 35-40: Unassigned
- 43-48: Unassigned
- 58-59: Unassigned
- 63-64: Unassigned
- 66-70: Unassigned
- 73-80: Unassigned
- 82-98: Unassigned

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care,

also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official UB-04 Data Specifications Manual.

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

National Drug Code (NDC)

The 11-digit National Drug Code number (NDC) must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, UB-04 or its electronic equivalent.

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

16. 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 – Health Care 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.

17. Covered and Non-Covered Days

Value code 80 (Covered Days) must be present on inpatient and long-term care claims or the claims will be denied. Institutional (UB) outpatient services are excluded from this requirement.

- Units billed with value code 80 are the number of covered full days and must correspond with units billed on the room and board claim line
- In the value code field, the number of covered days must be entered to the left of the dollars/cents delimiter
- Value Code 80 and corresponding units exclude non-covered days, leave of absence days or the day of discharge or death

Claims with non-covered days must bill value code 81 (Non-Covered Days) to indicate the total number of full days that are not reimbursable.

- Units billed with value code 81 are the number of non-covered full days and must correspond with units billed on the room and board claim line
- In the value code field, the number of non-covered days must be entered to the left of the dollars/cents delimiter
- Charges related to the non-covered days would be reported under Total Charges and Non-Covered Charges on the room and board claim line
- The discharge date or day of death should not be included as a non-covered day in the value code or the room and board line
- Claims reporting non-covered days must report an occurrence code of 74 with the date span of the non-covered days

Note:

- If the covered and non-covered days' values are not reported on separate lines, the claim will be denied
- The total covered days and non-covered days billed must match at the line and header level
- This process must be followed by the provider for billing collapsed preventable readmissions

For more information please visit medicaid.ohio.gov and review the "Appendix G – Value Codes" in the ODM Hospital Billing Guidelines located under "Resources," then "Publications" and "ODM Guidance."

18. FQHC Transportation Reimbursement

Pursuant to OAC 5160-28-03.1 Cost-based Clinics: FQHC Services, Co-Payments, and Limitations, Molina will pay a per trip fee for transportation services provided by all Federally Qualified Health Centers (FQHC) that have a transportation contract with the ODM.

- Trip must be to or from an FQHC service site where a covered visit takes place on the same date of service.
- Molina will be paying $25.00 per trip or the lessor of billed charges, regardless of units billed.
- Claim must be billed using T2003.

Part B Therapies: Therapy Cap Authorization Requirement

In accordance with the Bipartisan Budget Act (BBA) of 2018, Medicare Claims are no longer subject to the therapy caps:

- One cap for occupational therapy services.
- One cap for physical therapy and speech-language pathology combined.

For Molina Medicare Plans, Claims for therapy services above a certain amount of incurred expenses, which is the same amount as the previous therapy caps, continue to require prior authorization

19. Patient Liability

Patient Liability (PL) is the monthly amount that a Member may be required to contribute to the cost of their care depending on the individual state income regulations for the following services:

- Nursing Facilities
- Hospice
- Assisted Living
- Certain Home and Community-Based Waiver Services
- Personal Care Aide
- Home Care Attendant
- Nursing Services
- Adult Day Services

This amount is calculated using the Member's income and subtracting reasonable allowances for personal needs and other living expenses. Nursing facilities and home health agencies are

required to collect the entire PL due each month. Payments made to nursing facilities are reduced by the PL amount due for the months billed.

20. Claim Auditing

Molina shall use established industry Claim 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.

The Provider acknowledges Molina's right to conduct pre-and post-payment billing audits. The Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right, and where unprohibited by regulation, to 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 extrapolated 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.

Effective Coding of Evaluation and Management Services

In an ongoing effort to ensure accurate Claims processing and payment, Molina is taking additional steps to verify the accuracy of payments made to professional Providers. Beginning on August 1, 2020, as part of our claims process, Molina reviews select Claims for Evaluation and Management (E/M) services to better ensure that payments are aligned with national industry coding standards.

Providers should report E/M services in accordance with the American Medical Association's (AMA) CPT Manual and the Centers for Medicare and Medicaid Services' (CMS) guidelines for billing E/M service codes: Documentation Guidelines for Evaluation and Management. The level

of service for E/M service codes is based primarily on the Member's medical history, examination and medical decision-making. Counseling, coordination of care, the nature of the presenting problem and face-to-face time are considered contributing factors.

Medical Necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be Medically Necessary or appropriate to bill a higher level of evaluation and management service when a lower level or service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

CMS Regulations and Guidance 30.6.1/Selection of Level of Evaluation and Management Services, A – Use of CPT Code (cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf)

If you disagree with Molina's findings after this review, you have the right to appeal the decision. Please follow the standard Claim Reconsideration process indicated in the Provider Manual.

21. MyCare Ohio Timely Claim Processing

A complete Claim is a Claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in "Ordering, Referring and Prescribing (ORP) Providers NPI" earlier in this section, or particular circumstances that requiring special treatment that prevents timely payment from being made on the Claim.

Claim processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in writing, or an alternate schedule is required by ODM, Molina will process the Claim for services as follows:

Claims from independent (non-agency) providers for MyCare Ohio Home - and Community-Based Services (HCBS) Waivers services and private duty nursing (PDN):

- Pay or deny 90% of all submitted clean claims within 14 calendar days of the date of receipt of the claim;
- Pay or deny 99% of "clean" claims within 30 calendar days of the date of receipt of the claim; and
- Pay or deny 100% of all claims within 60 calendar days of receipt of the claim.

All other claim types (excluding claims from independent providers):

- Pay or deny 90% of all submitted clean claims within 21 calendar days of the date of receipt of the claim;.

- Pay or deny 99% of clean claims within 60 calendar days of the date of receipt of the claim; and
- Pay or deny 100% of all claims within 90 calendar days of receipt of the claim.

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

22. Electronic Payment Requirement

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

Molina has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/Automated Clearing House (ACH), a physical check or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt-out of receiving a Virtual Card prior to your first payment, you may contact ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Ohio be opted out of Virtual Cards.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the Molina Payer ID. Please ensure that your Practice Management System is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal (providerpayments.com).

If you have any difficulty with the website or have additional questions, ECHO has a Customer Services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Customer Services team at (888) 834-3511.

Once your account is activated, you will begin receiving all payments through EFT, and you will no longer receive a paper explanation of payment (EOP) (i.e., Remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download, and save historical and new ERAs with a two-year lookback.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at MolinaHealthcare.com.

If a Provider is not already enrolled for 835s with ODM, please visit this website to sign up: Required Forms & Technical Letters | Medicaid (ohio.gov). The ODM enrollment will provide ERAs from all payers in the Next Generation MyCare Ohio program.

23. 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 Provider Manual for more information.

24. Encounter Data

Each Provider, capitated Provider, or organization delegated for Claims processing is required to electronically accept Claims from the ODM OMES system and adjudicate all Claims to final status (payment or denial) within the timeframes specified and then submit encounter data to Molina and ODM's OMES PACDR encounters intake system for all adjudicated Claims. The data received is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement Program and HEDIS® reporting. Encounter data must be submitted weekly in order to meet the state and CMS encounter submission threshold and quality measures. Data must be submitted with Claims-level detail for all institutional and non-institutional services provided.

Providers/vendors/delegates must submit encounters no later than seven calendar days from completion of the Claim (i.e., remittance advice generated). In accordance with 42 CFR 438.604 and 42 CFR 438.606, the Provider/vendor/delegates must submit a certification letter with the submission of an encounter data file to Molina, ODM's OMES PACDR encounters intake system.

For CMS, 80% of Claims must be submitted within 180 days from the date of service. Additionally, effective from Jan. 1, 2026, for MyCare Ohio Medicaid, each capitated Provider, or organization delegated for Claims/Encounters processing is required to submit all (Percentage of compliance TBD) Claims/encounters and get accepted within 7 calendar days from the date the Claim/encounter received a paid or denied status in the Claims processing system.

Providers/Vendors/Delegates must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina and ODM OMES PACDR system.

Providers/Vendors/Delegates must have necessary edits that check for and prevent duplicates on encounter data submissions, as well as any other state contractual requirement where employing edits benefits encounter submissions and acceptance.

Providers/Vendors must be able to accept, send and process multiple versions of X12 transactions concurrently and follow the 837 PACDR Encounter Data Companion Guides standards (Companion Guides | Medicaid (ohio.gov)) in conjunction with the X12 Implementation Guides for EDI transactions for dental, professional and institutional encounter data submissions to OMES system, including allowed amount and paid amount in accordance with 42 CFR 438.242(c)(3).

Encounter submissions must reflect all Claims activity. Providers/Vendors must submit valid encounter data that include the application of specific edits, including checking for Member eligibility, managed care enrollment, valid current procedural terminology (CPT) codes, amounts paid by the subcontractor/vendor/delegate to the Provider on behalf of Molina and include Claim-level detailed information, cross field editing and valid line-level detail with meaningful Claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) accurately reflecting the data submitted to the servicing/billing Provider indicating final status of Claim adjudication.

Providers/Vendors must comply with all applicable provisions of HIPAA, including EDI standards for code sets and the following electronic transactions:

- ASC X12 837 299A1 - Post-adjudicated Claims data reporting (PACDR): INSTITUTIONAL.
- ASC X12 837 298A1 - Post-adjudicated Claims data reporting (PACDR): PROFESSIONAL.
- ASC X12 837 300A1 - Post-adjudicated Claims data reporting (PACDR): DENTAL.
- TA1 Transmission Acknowledgement.
- ASC X12 999 – Implementation acknowledgement file.
- ASC X12 270/271 – Eligibility and benefit verification and response.
- ASC X12 278 – Authorization/referral request and response.
- ASC X12 824 – Application advice.
- ASC X12 835 – Health care payment and remittance status file

B. Timely Filing Requirements

Providers will have 365 days to timely file a Claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) Rule 5160-1-19.

Timely Claim Filing

The Provider shall promptly submit Claims to Molina for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and

shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures.

If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within 90 calendar days after the 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 and the Provider hereby waives any right to payment.

Original Claims: Claims for Covered Services rendered to Molina Complete Care for MyCare Ohio Medicare-Medicaid Members must be received by Molina no later than the filing limitation stated in the Provider contract or within 365 days from the date of service(s) for MyCare Ohio. Claims submitted after the filing limit will be denied.

Corrected Claims: Claims received with a correction of a previously adjudicated Claim must be received by Molina no later than 365 calendar days from the date of the remit of the Claim number that is being corrected. Corrected Claims must be submitted with the Molina Claim ID number from the original Claim being corrected, and with the appropriate corrected Claim indicator based on Claim form type. Claims submitted after the filing limit will be denied.

Coordination of Benefits: Claims received with explanation of benefits (EOB) from the primary carrier attached must be submitted to Molina within 90 days of the date listed on the EOB from the other carrier.

The Provider may request a review for Claims denied for untimely filing by submitting justification for the delay as outlined in the Claim Reconsiderations section below. Acceptable proof of timely filing must include documentation with the following:

- The date the Claim was submitted.
- The insurance company billed (address/payer ID) was Molina.
- The Claim record for the specific patient account(s) in question.

Claim Reconsideration Requests (Disputes): See the Claim Reconsiderations section below for information and timeframes regarding review of a Claim payment and/or denial.

Refer to the ODM Designated Provider and Non-Contracted Provider Guidelines for timely filing and Claim reconsideration requirements specific to non-participating Providers.

C. Monitoring Claims and Explanation of Benefits (EOB)

Monitoring Claims

Molina employs various methods and tools for monitoring Claims payment accuracy and timeliness. These checkpoints can take place both pre and post-payment and sometimes involve third party vendors. Some of the tools utilized are the National Correct Coding Initiative,

National and Local Coverage Determinations, as well as high dollar reviews. When a Claim is identified for prepayment review; Providers will receive notice either through a letter or a remittance remark code. When Claims are identified through a post-payment audit Providers will receive a notice giving them the issue identified and the dispute process for our findings. Providers always have reconsideration rights for both pre and post-payment audits.

In addition, Molina analyzes Claims operations reporting to track and trend within the Claims data. The results of these ongoing reviews are leveraged for Provider outreach, training and education to individual Providers and widespread messaging to address global trends.

Explanation of Benefits

Claims received with an explanation of benefits (EOB) from the primary carrier attached must be submitted to Molina within the greater of 365 from the Claim remit date or within 90 days of the date listed on the EOB from the other carrier. The Provider may request a review for Claims denied for untimely filing by submitting justification for the delay as outlined in the Claim Disputes section of this Manual.

Acceptable proof of timely filing must include documentation with the following:

- The date the Claim was submitted.
- The insurance company billed (address/payer ID) was Molina.
- The Claim record for the specific patient account(s) in question.

D. Payment in Full Information

Balance Billing

Pursuant to Law and CMS guidance, Members who are dually eligible for Medicare and Medicaid and classified as Qualified Medicare Beneficiaries (QMB) shall not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Organization is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Molina Member for Covered Services is prohibited, other than for the Member's applicable copayment, coinsurance and deductible amounts.

Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state or another payer such as a Medicaid Managed Care Organization is responsible for paying such amounts.

In accordance with OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements, a Provider may only bill a Molina Member when the Managed Care Organization (MCO) has denied prior authorization or referral for services and the following conditions are met:

- The Member was notified by the Provider of the financial liability in advance of service delivery.
- The notification by the Provider was in writing, specific to the service being rendered, and clearly states that the Member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose.
- The notification is dated and signed by the member.

The agreement must be specific to the services being rendered and clearly state:

- The service is not covered by ODM or Molina.
- The service is determined not to be medically-necessary by Molina's Utilization Management Department.
- The Member is choosing to receive the service and agrees to pay for it, even though the service may have been determined by Molina to be not medically-necessary.
- The Member is under no obligation to pay the Provider if the service is later found to be a Covered Benefit, even if the Provider is not paid because of non-compliance with Molina's billing and/or prior authorization requirements.
- For Members with limited English proficiency, the agreement must be translated or interpreted into the Member's primary language to be valid and enforceable.
  - This interpretation/translation service is the responsibility of the Provider to supply.
- The written notification must be specific to the services to be provided, and clearly state the Member is financially responsible for the specific service.
  - A general patient liability statement signed by all patients at your practice does not meet this requirement.
- The written notification must be signed and dated by the Member and the date must be prior to date of service.

Please Note: Billing Members for missed appointments is prohibited. Molina provides transportation to Members for scheduled appointments and provides education to Members regarding the importance of maintaining appointments. Providers should call Provider Services at (855) 322-4079 to determine if billing Members for any services is appropriate.

E. Member Co-Payments

Molina does not require Member co-payments for Medically Necessary, Medicaid Covered Services.

Please consult the Molina Complete Care for MyCare Ohio Member Handbook on the Member Resources page for co-payment information for dual benefits members for Part D drugs.

Members can still receive the service if they cannot pay the co-pay at the time of service, and, if applicable, the member will still owe the provider the co-pay.

Providers can refuse to provide future services for unpaid co-pays if they notify the member in advance.

F. Process and Requirements for Appeal of Denied Claims (Provider Claims Dispute Resolution Process)

Definitions of terms for Provider Appeal and Claim Dispute processes:

Clinical Claim Dispute—Formerly known as an "authorization reconsideration." A post-Claim Provider dispute for the denial of a Prior Authorization or for the denial of a retro-authorization request for Extenuating Circumstances. The Clinical Claim Dispute must be post-Claim and submitted within 365 days of the date of service or 60 days from the remittance advice; whichever is later. Providers may submit a Clinical Claim Dispute via the Availity Essentials portal, fax or verbally. If submitted verbally, Providers must still submit the necessary information to Molina to support the dispute. To submit via fax, the Clinical Claim Dispute must be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form). Decisions will be made within 30 business days.

Retro-Authorization request for Extenuating Circumstances—This process can occur pre- or post-Claim and serves as an initial Medical Necessity review with a dispute right available after an adverse determination. Both the initial review and dispute processes must be exhausted before the Provider is eligible for an External Medical Review.

- **If Pre-Claim—**Initial Medical Necessity request and the dispute follow the Authorization Appeal submission process and timeframes.
- **If Post-Claim—**Initial Medical Necessity request and the dispute follow the Clinical Claim Dispute submission process and timeframes.

Non-Clinical Claim Dispute—Formerly known as a "Claim reconsideration." This process is used only for disputing a payment denial, payment amount, or a code edit. The Non-Clinical Claim Dispute must be post-Claim and submitted within 365 days of the date of service or 60 days from the remittance advice; whichever is later. Providers may submit a Non-Clinical Claim Dispute via the Availity Essentials portal, fax, or verbally by calling the Provider Services Contact Center. To submit via fax, the Non-Clinical Claim Dispute must be submitted on the Claim Reconsideration Form (Non-Clinical Claim Dispute Form). Decisions will be made within 15 business days or with continued communication if Molina needs more time to address the dispute.

See the VII. Utilization Management section of this Provider Manual for more information on Authorization Appeals.

For additional guidance on these processes, please consult the MyCare Ohio Authorization Appeal and Claim Dispute Reference Guide on the Molina Website.

Non-Clinical Claim Disputes (not related to an Authorization/Medical Necessity Review)

Provider Claims Dispute Resolution Process (Claim Disputes)

- Provider claim disputes include any level of dissatisfaction with claims determination such as reconsiderations, appeals, and escalated provider claim inquiries. Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.
- Providers may submit claim disputes verbally or in writing, including through the provider portal.
- After exhausting Molina's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

Provider Claim Payment Disputes, Appeals and Inquiries

Provider Claim Payment Disputes

A Provider Claim payment dispute is the mechanism that should be used if a Provider disagrees with the denial of payment/partial payment of their Claim, which does not involve a denial of payment/partial payment related to Medical Necessity. Examples include, but are not limited to:

- Contractual payment issues
- Disagreements over reduced Claims or zero-paid Claims not related to Medical Necessity
- Post-service authorization issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues*

**Timely filing issues: Molina will consider reimbursement of a Claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the Claim was submitted within the timely filing requirements; or 2) good cause can be demonstrated, which is left to the sole discretion of Molina to determine.*

Provider Claim payment disputes must be submitted with a statement of what the Provider believes is the issue as well as all necessary documentation to support the dispute, such as

coding requirements, contracts, state and/or federal regulations and payment policies. If incomplete information is supplied, then it will cause the Claim payment dispute to be dismissed.

Provider Claim Payment Appeals (Clinical Claim Disputes)

Claims that were denied for lack of Medical Necessity should follow the Provider Claim payment appeal process. A Provider Claim payment appeal is a formal request for review of a previous Molina decision where Medical Necessity was not established, including partial stay denials and level of care. One example of this appeal scenario would be as follows (this is not all encompassing, but serves as a singular example):

- On clinical review, the services related to the prior authorization request were:
  - Deemed not Medically Necessary, but services were rendered and Claim payment was denied.
  - Some days were deemed not Medically Necessary, but services were rendered and Claim payment was denied.

When submitting a Provider Claim payment appeal, please include any information that would help Molina determine why the Provider believes the services were Medically Necessary, including all necessary medical records.

Provider Claim Payment Inquiries

Any inquiry where the Provider believes the Claim was paid or denied incorrectly due to minor errors that can be easily remediated, **without** providing supporting documentation. Examples include retro-eligibility issues, coordination of benefit updates, Claims denied as duplicates and Claims denied for no authorization when authorization was not required or an approved authorization is on file. Supporting documentation cannot be submitted with a Claim payment inquiry. This inquiry may result in a Claims adjustment or direct you to submit a Corrected Claim or initiate the Claim Payment Dispute/Appeal process.

For the avoidance of doubt, in the event a Provider Claim payment inquiry has been filed for a Claim it will not toll the time frame for filing a Provider Claim payment dispute or Provider Claim payment appeal.

Timeframe for submitting a Provider Claim Payment Dispute or Claim Payment Appeal

Please note, neither a Provider Claim payment dispute nor a Provider Claim payment appeal can be reviewed without a finalized Claim on file.

Molina accepts disputes and appeals in writing via mail or fax or through the Availity Essentials portal within 60 calendar days from the date on the Explanation of Payment (EOP) unless a different time frame is specified in the Provider Agreement with Molina. Requests filed beyond

these timeframes will be untimely and denied unless good cause can be established, which is left to the sole discretion of Molina to determine.

The plan will make every effort to resolve the Claims payment disputes and Claims payment appeals within 15 calendar days of receipt, unless otherwise specified by the Provider Agreement with Molina or a different timeframe is required by law.

Molina will send you our decision in a determination letter when upholding our decision, which will include the reason and rationale for the upheld decision.

If the decision results in a Claim adjustment, the payment and Explanation of Payment (EOP) will be sent separately.

How To Submit a Provider Claim Payment Dispute or Claim Payment Appeal or Claim Payment Inquiry

Providers have several options to file a Claim payment dispute, Claim payment appeal, or Claim payment inquiry:

- **Online**: Use the secure Availity Essentials Portal to submit a Claim payment dispute, Claim payment appeal, or Claim payment inquiry. Instructions on how to file a Claim payment dispute, Claim payment appeal, or Claim payment inquiry is available on the Availity Payer Spaces Resources tab.
- **Written**: Provider Claim payment disputes and Provider Claim appeals can also be mailed or faxed to (Provider Claim payment inquiries **cannot** be used for this method of delivery):
  - **Mail**: PO Box 22816, Long Beach, CA 90801-9977; or
  - **Fax:** (562) 499-0610
- **Phone (for Provider Claim Payment Inquiries only):**
  - **Phone:** (855) 322-4079

Note: Please include the authorization number on all Claims submitted to Molina for services rendered that require authorization per the "Authorization Lookup tool." Please make sure that you are authorizing services prior to rendering, 24 hours after inpatient admission or sooner and prior to any outpatient or in-patient planned (admission) service or other service that requires authorization. **PA Lookup Tool** .

Providers can submit appeals and/or disputes via the below methods:

- Availity portal (preferred method) link: Availity.com/providers
- Fax: (562) 499-0610
- Verbally

Provider Claim Payment Inquiries/Reconsiderations (Availity Essentials portal):

Previously known as a reconsideration. A review of a Claim that the Provider believes was paid or denied incorrectly. The Provider suspects a minor error that can easily be remediated. Examples include retro-eligibility issues, coordination of benefit updates, Claims denied as a duplicate in error and Claims denied for no authorization when authorization is not required or when an approved authorization is on file. **The Provider cannot submit supporting documentation with a Claim payment inquiry.** A payment inquiry may result in a Claims adjustment, or the outcome may direct the Provider to submit a Corrected Claim or initiate the Claim Payment Dispute/Appeal process.

Extenuating Circumstances

Extenuating Circumstances can be submitted pre- or post-Claim using the Authorization Appeal or Clinical Claim Dispute methods noted above.

Below is the list of Extenuating Circumstances that apply to both inpatient and outpatient authorization requirements. Within 60 calendar days of the Claim denial or within 365 days of the date of service; whichever is greater, the Provider may file a Clinical Claim Dispute for the extenuating circumstances listed below, even if the authorization was not requested in advance of the service(s) being provided. The specific circumstance the Provider feels was applicable to the request should be noted on the reconsideration form, documentation to support the extenuating circumstance, as well as the applicable clinical information should be included with the request. In accordance with Molina policy, please remember to always verify enrollment using the ODM PNM system:

- A newborn remains an inpatient longer than the Member and needs separate authorization.
- Member was brought into the facility unconscious and/or unable to provide insurance carrier information (Requires Provider to submit a copy of registration face sheet and complete description of why the documentation could not be obtained from the Member. In addition, Molina will review the Claims/authorizations history for the past six months for validation purposes).
- Retro-enrollment/retro coordination of benefits (COB) change makes Molina the primary carrier.
- The Transition of Care/Continuity of Care.
- Abortion/Sterilization/Hysterectomy (operative reports are required).
- The service is not an included benefit in the primary insurance coverage (for example: no maternity care benefits).
- A baby is born to a Member with other third party primary coverage, and the baby is not covered under such coverage.
- Add-on codes or changes in coding during the procedure (operative reports are required as applicable).
- Other circumstances as determined by Molina.

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

Claims that Denied for an Itemized Bill:

All Claim/Claim lines that deny for an itemized bill on the Explanation of Payment (EOP) remit, must be sent with a corrected Claim via the Availity Essentials portal submission or to the address below. The corrected Claim and the itemized bill must match for the reconsideration to be completed.

Use the Availity Essentials portal to submit an itemized bill with your claim online.

- You can access the Availity Essentials portal at availity.com/providers/.
- Attachments totaling up to 640 MB can be included with new or corrected claims.

Overpayments and Incorrect Payments Refund Requests

In accordance with 42 CFR 438.608, Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within sixty (60) calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

If, as a result of retroactive review of Claim payment, Molina determines that it has made an overpayment to a Provider for services rendered to a Member, Molina will make a request 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.

A copy of the overpayment request letter and details are available in the Availity Provider portal.

In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment, or check status. This is Molina's preferred method of communication.

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.

If you have any questions regarding a refund request letter, please call the Claims Recovery Unit at (866) 642-8999 and follow the prompts to Ohio. Or call Molina Provider Services at (855) 322-4079. View the Return of Overpayment form on the Provider Website.

In the event the Provider incorrectly receives a check or finds an overpayment, please send the refund with a copy of the remittance advice and Claim information to:

Please direct payment and any correspondence to:

Molina Healthcare of Ohio
Dept. 781661 PO Box 78000
Detroit, MI 48278

If returning a Molina Healthcare check, please send to:

Molina Healthcare of Ohio
PO Box 349020
Columbus, OH 43234-9020

Overpayment Dispute Process

Molina allows the Provider 30 calendar days from receipt of the notice to submit a written response disputing the overpayment or requesting an extended payment arrangement or settlement. If the provider fails to submit a written response within the time period provided, Molina may execute the recovery as specified in the notice. Please follow the instructions on

the overpayment letter detailing how to submit a dispute which includes the mailing address and fax number to ensure proper receipt of the dispute. Providers may also submit an overpayment dispute via the Availity Essentials portal by following the standard Claim dispute process outlined in this Provider Manual.

Providers have access to view overpayment letters directly in the Availity Essentials portal. To accompany this access, Molina launched a new process for submitting overpayment disputes through the Availity Essentials portal. Please review the Provider Bulletins posted on Molina's website for more information about this new process and how to access training.
Molina provides a written notice of determination that includes the rationale for the determination. If Molina determines the facts justify the recovery, Molina may execute the recovery within three (3) business days of sending the notice of determination.

IX. Care Coordination/Care Management

A. Description of Molina's Care Coordination and Care Management Program

Care Management (CM)

The Integrated Care Management (ICM) Program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. Care Management focuses on the delivery of quality, cost-effective, and appropriate health care services for Members. Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems, and social determinants of health to target high-needs Members who would benefit from more intensive support and education from a Care Coordinator. Additionally, functional, social support, and health literacy deficits are assessed, as well as safety concerns and caregiver needs.

1. **The role of the Care Coordinator includes:**

   - Coordination of quality and cost-effective services.
   - Appropriate application of benefits.
   - Promotion of early, intensive interventions in the least restrictive setting of the Member's choice.
   - Assistance with transitions between care settings and/or Providers.
   - Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans.
   - Creation of ICPs, updated as the Member's conditions, needs and/or health status change.
   - Facilitation of Interdisciplinary Care Team (ICT) meetings as needed.

- Promote utilization of multidisciplinary clinical, behavioral and rehabilitative services.
- Referral to and coordination of appropriate resources and support services, including but not limited to Managed Long-Term Services & Supports (MLTSS).
- Attention to Member preference and satisfaction.
- Attention to the handling of Protected Health Information (PHI) and maintaining confidentiality.
- Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence.
- Protection of Member rights.
- Promotion of Member responsibility and self-management.

2. **Referral to Care Management may also be made by the following entities:**

- Member or Member's designated representative(s)
- Member's Primary Care Provider
- Specialists
- Discharge Planner
- Hospital Staff
- Home Health Staff
- Molina staff

B. **Role of Provider in Care Coordination and Care Management Programs in accordance with OAC Rule 5160-26-05.1**

Coordination of Care and Services

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

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

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

- Notification of community resources, local or state funded agencies.
- Education about alternative care.

- How to obtain care as appropriate.

Continuity of Care and Transition of Members

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

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide Covered Services to the Member for 90 days or for as long as the treatment plan requires. Then the member will be safely transferred to another Provider by Molina or its delegated Medical Group/IPA.
- Pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4079.

Continuity and Coordination of Provider Communication

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

Reporting of Suspected Abuse and/or Neglect:

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

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

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or child care givers.

- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

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

Child Abuse:

The Ohio Department of Job and Family Services has launched 855-O-H-Child (855-642-4453), an automated telephone directory that will link callers directly to a child welfare or law enforcement office in their county.

Adult Abuse:

Adult protective services for adults age 60 and older can be reached at the Ohio Department of Job and Family Services at 855-OHIO-APS (855-644-6277).

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

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

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

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

C. Care Coordination Delegation Information

Molina does not delegate Care Coordination in the MyCare Ohio Program.

D. Behavioral Health Care Coordination

Overview

Molina provides a behavioral health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty care Providers to ensure whole-person care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral health inpatient, substance use disorder residential services, psychiatric residential treatment and select outpatient treatment(s) can be requested by submitting a Prior Authorization (PA) to Molina via EDI or the Availity Essentials portal. Molina strongly recommends the use of the Availity Essentials portal to submit all prior authorization requests.

Emergency psychiatric services do not require PA. All requests for behavioral health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification as well as current clinical information supporting the request. Molina utilizes standard, generally accepted Medical Necessity criteria for PA reviews.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge and to occur within seven days of the discharge date.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration amongst all Providers on the Member's interdisciplinary care team (ICT). Behavioral health, primary care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care

Management Program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

Care Management

Molina's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or Substance Use Disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs may be referred by a behavioral health professional or Primary Care Provider to the Care Management Program.

Referrals to the Care Management Program may be made by contacting Molina at: Phone: (855) 322-4079, from 8 a.m. to 8 p.m., Monday through Friday

For additional information on the Care Management Program please refer to the Care Management subsection found in the Health Care Services section of this Provider Manual.

Behavioral Health Care Management

Access to Records and Information to Support Member Care Coordination and Care Management Activities

Molina is committed to working with its Providers to address the care coordination and care management needs of its Members. To facilitate such activities, all Providers (including substance use disorder providers and behavioral health providers) are required to cooperate with and provide to Molina any and all relevant patient/Member records and information requested by Molina to support such activities. To the extent a consent and/or authorization from the patient/Member is required by law to disclose the requested records/information to Molina, the Provider shall make best efforts to obtain the necessary consent(s) and/or authorization(s) from the patient/Member.

Both Molina and the Provider agree to comply with HIPAA and other applicable federal and state privacy laws and regulations including, but not limited to, the HIPAA privacy regulations set forth in 45 C.F.R. Part 164 Subpart E, the HIPAA security regulations set forth in 45 C.F.R. Part 164 Subpart C, 42 C.F.R. Part 2 Regulations governing the Confidentiality of Substance Use Disorder Patient Records and state-specific medical privacy laws.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment, and diagnosis of common behavioral health conditions, plus access to Behavioral Health HEDIS® Tip Sheets and other evidence-based guidance, training opportunities for providers, and recommendations for coordinating Member care. The material within this tool kit is applicable to Providers in both medical and behavioral health settings. The Behavioral

Health Tool Kit for Providers can be found under the "Health Resources" tab on the MolinaHealthcare.com Provider Website.

For information about the OhioRISE program and eligibility please visit the ODM OhioRISE website.

X. Reporting

A. Member 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 in accordance with OAC Rule 5160-26-05.1. 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 during 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, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity
- Storage maintenance for the determined timeline and disposal are managed per record management processes
- Process is in place 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 must remain consistent in their practices with Molina's medical record documentation guidelines. Medical records are maintained and should include, but not be limited to the following information. All medical records should contain:

- The patient's name or ID number on each page in the record.
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact.
- Legible signatures and credentials of the Provider and other staff members within a paper chart.
- A list of all Providers who participate in the Member's care.
- Information about services that are 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 the inpatient discharge with evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that shows Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits, that include: 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 as 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 and follow-up care, inpatient and outpatient care, including 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.

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

- Education and training for all staff on handling and maintaining protected health care information.
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity, and social determinants of health.

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

B. Policies and Procedures for Molina Action in Response to Undelivered, Inappropriate, or Substandard Health Care Services

In accordance with OAC 5160-26-05.1, Molina has established a systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable) and/or service issues affecting Member care. Potential Quality of Care issues are referred to the Potential Quality of Care Team for investigation. A Molina Medical Director reviews all referrals and determines what actions may be indicated in substantiated cases. All substantiated cases are tracked and trended. Cases assigned severity levels 3 and 4 are referred to the Professional Review Committee. Depending on the findings of the investigation, disciplinary action may be taken against the Provider up to and including Corrective Action Plan issuance or network termination. Providers are expected to participate fully in the investigation if they receive outreach from Molina.

C. Reporting Provider Preventable Conditions/Health Care-Acquired Conditions

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

The following is a list of CMS Hospital Acquired Conditions. CMS reduced payment for hospitalizations complicated by these categories of conditions that were not Present on Admission:

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries

   e. Burn
   f. Other Injuries
6. Manifestations of Poor Glycemic Control
   a. Hypoglycemic Coma
   b. Diabetic Ketoacidosis
   c. Non-Ketotic Hyperosmolar Coma
   d. Secondary Diabetes with Ketoacidosis
   e. Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
   a. Spine
   b. Neck
   c. Shoulder
   d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
   a. Laparoscopic Gastric Restrictive Surgery
   b. Laparoscopic Gastric Bypass
   c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following Certain Orthopedic Procedures
   a. Total Knee Replacement
   b. Hip Replacement

What this means to Providers

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

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

D. Incident Reporting

Providers are required to ensure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500, and accidental/unnatural deaths. If actions were not taken to ensure the immediate health and safety of the members, the provider will do so immediately. Such actions may include calling police or emergency medical services or regulatory agencies such as the Ohio Department of

Health. Providers are required to report these types of incidents to the MCOP within 24 hours of becoming aware of the incident.

E. How to Submit an Incident to Molina

Pursuant to OAC Rule 5160-44-05, Molina requires maintaining an incident management process whereby instances in which Member health, safety and/or welfare may be at risk are reported to appropriate agencies and the Ohio Department of Medicaid (ODM). If a Provider receives a report of a Medicaid Critical Incident or identifies a Medicaid Critical Incident, Provider must take immediate action to ensure health, safety and welfare (HSW) of the individual, notify appropriate agencies/authorities, complete the Medicaid Critical Incident Referral Template in its entirety and send securely to CriticalIncident@MolinaHealthcare.com no later than 24 hours from the time of incident discovery.

XI. Member Enrollment, Eligibility, Disenrollment

Enrollment

Overview

Molina Healthcare offers two distinct plans under the MyCare Ohio program:

- Molina Complete Care for MyCare Ohio (HMO D-SNP/FIDE) (Dual Benefits)
- Molina MyCare Ohio Medicaid (Medicaid Only)

Enrollment in the Molina Complete Care MyCare Ohio Plan

Molina Complete Care for MyCare Ohio is the brand name of Molina's Medicare-Medicaid plan, part of the MyCare Ohio program. Members who wish to enroll in Molina Complete Care for MyCare Ohio must meet the following eligibility criteria:

To be eligible for membership in the MyCare Ohio managed care plan, Members must meet the following criteria:

- Have Medicare parts A, B and D; and
- Have full Medicaid coverage; and
- Are 21 years of age or older at the time of enrollment.

Members are not eligible to enroll in a MyCare Ohio managed care plan if any of the following apply:

- Do not have full Medicaid benefits and Medicare parts A, B and D;

- Are younger than age 21;
- Are enrolled in Program for All-Inclusive Care for the Elderly (PACE);
- Has private creditable medical insurance, including retiree benefits, other than a Medicare advantage plan; or
- Has intellectual or other developmental disabilities and receives services through a waiver or intermediate care facility for individuals with intellectual disabilities (ICF-IID).
- Receives home and community-based waiver services through the Ohio Department of Developmental Disabilities.

Additionally, Members may choose not to be part of a MyCare Ohio managed care plan if they are part of a federally recognized Indian tribe.

Effective Date of Enrollment

The Member effective date is determined by ODM and passed to Molina on the ODM eligibility file.

Verifying Eligibility

To ensure payment, Molina strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of a Molina ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

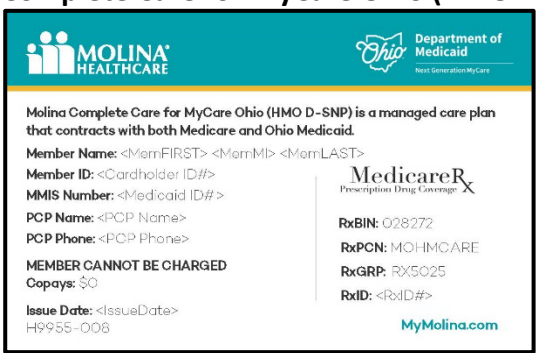
Providers who contract with Molina may verify a Member's eligibility and/or confirm PCP assignment by checking the following:

1. Log in to the ODM PNM system
2. Call the ODM Interactive Voice Response (IVR) System 24 hours a day, seven days a week, 365 days a year to confirm eligibility for MyCare Ohio, managed Medicaid or Fee-for-Service Medicaid consumers. Providers must have a PIN number to access this information.
3. Log on to the availity.com/providers/.
4. Call Provider Services at:
    - Molina Complete Care for MyCare Ohio/Molina MyCare Ohio Medicaid: (855) 322-4079, Monday through Friday from 8 a.m. to 8 p.m.
5. Check your current eligibility roster (PCPs only).
    1. Eligibility rosters can be accessed through the Availity Essentials portal
    2. Log in with your Username and Password
    3. Go to the Molina Payer Spaces
    4. Select Reports Tab
    5. Select Eligibility Roster

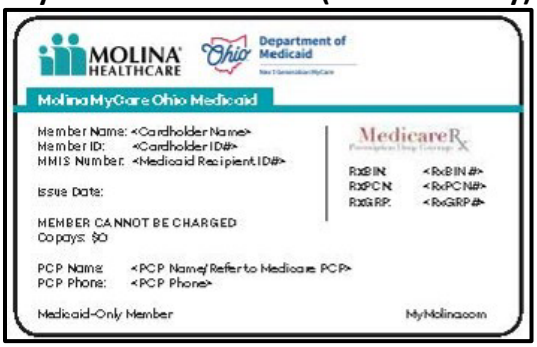
Possession of a Molina Member ID Card does not mean an individual is eligible for services. A Provider should verify a recipient's eligibility each time the recipient receives services. The Availity Essentials portal, Provider Services Contact Center, or the Ohio Department of Medicaid Provider Network Management (PNM) system can be used to verify a recipient's enrollment in a MyCare Ohio plan.

A. Identification Cards

Molina Complete Care for MyCare Ohio (HMO-DSNP) (dual benefits)



Molina MyCare Ohio Medicaid (Medicaid Only)



Members are reminded in their Member Handbooks to carry their Molina ID cards with them when requesting medical or pharmacy services. The Member Identification Card presented by a Molina Member may look different than the sample cards above. It is the Provider's responsibility to ensure Molina Members are eligible for benefits before rendering services. Unless an emergency medical condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

B. Disenrollment

Molina Complete Care for MyCare Ohio Disenrollment

The Molina Complete Care for MyCare Ohio plan staff may never, verbally, in writing or by any other action or inaction, request or encourage a Molina Complete Care for MyCare Ohio (dual benefits) Member to dis-enroll except when the Member has :

1. A change in residence (includes incarceration – see below) makes the individual ineligible to remain enrolled in the Molina Complete Care for MyCare Ohio plan.
2. The Member loses entitlement to either Medicare Part A or Part B.
3. The Member loses Medicaid eligibility (for a dual eligible member enrolled in a Molina Medicare Complete Care plan).
4. The Member dies.
5. The Member materially misrepresents information to the Molina Complete Care for MyCare Ohio plan regarding reimbursement for third party coverage.

Requested Disenrollment

The Molina Complete Care for MyCare Ohio plan will refer the Member to ODM (or their designated vendor) to process disenrollment of Members from the health plan only as allowed by ODM regulations. The Molina Complete Care for MyCare Ohio plan may request that a Member be disenrolled under the following circumstances:

- Member requests disenrollment.
- Member enrolls in another plan (during a valid enrollment period);
- Member leaves the service area and directly notifies Molina of the permanent change of residence;
- Member loses entitlement to Medicare Part A or Part B benefits;
- Member loses Medicaid eligibility;
- Molina loses or terminates its contract with CMS. In the event of plan termination by CMS, Molina will send CMS-approved notices and a description of alternatives for obtaining benefits. The notice will be sent timely, before the termination of the plan; and/or,
- Molina discontinues offering services in specific service areas where the Member resides.

In all circumstances except death, Molina will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

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

Involuntary Disenrollment

The reasons that Molina can ask to terminate membership include:

- Fraud or misuse of the Member's Molina ID card.
- Molina Complete Care for MyCare Ohio may request that a Member be disenrolled under the following circumstances:
  - Member enrolls in another plan.
  - Member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan Members.

- An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment.

Molina will send three written notices to the Beneficiary, including:

- an explanation of the disruptive conduct and its impact on the Plan's ability to provide services.
- examples of the types of reasonable accommodations the Plan has already offered.
- the Grievance procedures.
- an explanation of the availability of other accommodations.

The following reasons are additional causes for disenrollment (where Molina will notify ODM to begin the disenrollment process):

- Member abuses the identification card by allowing others to use it to fraudulently obtain services.
- Member has not permanently moved but has been out of the service area for six months or more.
- Molina Complete Care for MyCare Ohio loses or terminates its contract with CMS:
  - In the event of plan termination by CMS, Molina Complete Care for MyCare Ohio will send CMS-approved notices and a description of alternatives for obtaining benefits.
  - The notice will be sent timely, before the termination of the plan.
- Molina Complete Care for MyCare Ohio discontinues offering services in specific service areas where the Member resides.

When Members permanently move out of Molina's service area or leave Molina's service area for more than six consecutive months, they must disenroll from Molina's programs. There are a number of ways that the Molina Enrollment Accounting Department may be informed that the Member has relocated:

- Out-of-area notification received from ODM and forwarded to CMS on the monthly membership report.
- Through the CMS daily transaction reply report (DTRR) file (confirms that the Member has dis-enrolled).
- The Member may call to advise Molina Complete Care for MyCare Ohio that they have relocated, and Molina will direct the Member to ODM for formal notification.
- Other means of notification may be made through the Claims Department if out-of-area Claims are received with a residential address other than the one on file. (Molina does not offer a visitor/traveler program to Members).

In all circumstances except death, ODM (or its designated enrollment vendor) will provide a written notice to the Member. All notices will be in compliance with CMS regulations and will be approved by CMS. Each notice will include the process for filing a grievance.

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

Providers or Members may contact our Member Services Department to discuss enrollment and disenrollment processes and options at:

- Molina Complete Care for MyCare Ohio: (855) 665-4623 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.
- Molina MyCare Ohio Medicaid: (855) 687-7862 (TTY 711), Monday through Friday from 8 a.m. to 8 p.m.

C. Primary Care Provider (PCP) Assignment

Molina Members are encouraged to choose their own PCPs upon enrollment. If the Member or their designated representative does not choose a PCP, one will be assigned to the Member based on reasonable proximity to the home address. Molina Complete Care for MyCare Ohio Medicaid Members will not be assigned a PCP. These Members will continue to use their Medicare PCPs.

D. PCP Changes (Molina Complete Care for MyCare Ohio Dual Benefit Members only)

If for any reason a Member wants to change their PCP, they must call Member Services to ask for the change. PCP changes are permitted every 30 days if needed. If Molina assigned the Member to the PCP and the Member calls within the first month of membership with Molina, the change will be effective the day of the call. Molina will send the Member something in writing that states who the PCP is by the date of the change. PCP changes completed by the 15th of the month will have a start date of the first day of the second following month (i.e., a change made on January 16 will have an effective date of March 1). A new ID card is sent to the Member when a PCP change is made.

XII. Quality

A. 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) 322-4079.

The address for mail requests is:

Molina Healthcare of Ohio, Inc.
Quality Department
3000 Corporate Exchange Drive
Columbus, OH 43231

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

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

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

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

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe health practices for our Members through our Safety Program, Pharmaceutical Management and Care Management/Health Management Programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

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

B. Quality of Care

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

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

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

C. Advance Directives (Patient Self-Determination Act)

Molina complies with the Advance Directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. There are four types of Advance Directives in Ohio:

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions.
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Guardian Appointment:** allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.
- **Declaration for Mental Health Treatment:** allows a member to appoint a representative to make decisions while they lack the capacity to do so.

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

Providers must inform adult Molina Members, 18 years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, and other Member communications such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide advance directive information to the Member's family or representative and will follow up with information to

the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or visit Midwest Care Alliance's website at: caringinfo.org/planning/advance-directives/by-state/ohio/ as a resource and to access forms for download. Additionally, the Molina website offers information to both Providers and Members regarding Advance Directives, with a link to forms that can be downloaded and printed.

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

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

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

Ohio law includes a conscience clause. If a Provider cannot follow an Advance Directive because it goes against their conscience, they must assist the patient in finding another Provider who will carry out the patient's wishes. Under Ohio law, patients have the right to file a complaint related to Advance Directives with the Ohio Department of Health.

Molina will notify the Provider of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Advance Directives forms are state specific to meet state regulations.

Molina expects that there will be documented evidence of the discussion between the Provider and the Member during routine Medical Record reviews.

Improving the Coordination and Continuity of Member Health Care

- Molina investigates and resolves all potential quality of care issues specific to coordination of care, involving appropriate practitioners and Providers as needed.
- A focused medical record audit for evidence of coordination of care is conducted annually, and deficient offices may receive a Corrective Action Plan (CAP) request based on this review. In order to ensure continuity and coordination of care, a follow-up review of medical records will be conducted for offices that have been issued CAPs.

- Molina conducts a Provider Satisfaction Survey including assessment of Providers' satisfaction with coordination of care between settings.
- Molina promotes enhanced communication between primary care Providers (PCPs) and specialty care practitioners by requiring specialty care practitioners to provide treatment notes to the PCP.
- Molina conducts the Consumer Assessment of Health Plan Survey (CAHPS®) to improve Member satisfaction.

D. Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted PCPs (family/general practice, internal medicine, and pediatric) and participating specialists (to include OB/GYN, behavioral health Providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

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

Appointment Standards:

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week
Urgent Care (includes medical, behavioral health, and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance	24 hours, 7 days/week

Type of Visit	Description	Minimum Standard
	dependence that impacts the ability to function, but does not present imminent danger.	
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
American Society of Addiction Medicine (ASAM) Residential/Inpatient Services — 3: 3.1, 3.5, 3.7	Initial screening, assessment, and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services — 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Primary Care Appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 30 business days

Type of Visit	Description	Minimum Standard
Non-Urgent Sick Primary Care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days
Prenatal Care — First or Second Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	First appointment within 7 calendar days; follow-up appointments no more than 14 calendar days after request
Prenatal Care — Third Trimester or High-Risk Pregnancy		Within 3 calendar days
Specialty Care Appointment	Care provided for a non-emergent/ non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

Providers must offer hours of operation that are no less than the hours of operation offered to commercial Members or comparable to Medicaid fee-for-service, if the Provider serves only Medicaid Members.

Additional information on appointment access standards is available from your local Molina Quality Department at (855) 322-4079.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour telephone service, 7 days a

week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

Member's Obstetric and Gynecological Health Access

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

Ohio regulations require that a Member be permitted direct access to contracted obstetric and gynecological health care Providers without a referral or prior authorization. Member's obstetric and gynecological health services must be obtained from a Molina network Provider or a Qualified Family Planning Provider (QFPP). Members may seek direct care from any participating obstetric and gynecological health care Provider or QFPP for any of the following types of service:

- Maternity
- Gynecological
- Preventive care
- Other health problems discovered and treated during the course of the visit which are within the Provider's scope of practice

Additional information on access to care is available from your local Molina Quality Department.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement and Health Equity Transformation Committee on an annual basis.

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

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

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

Quality of Provider Office Sites

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

- Physical Accessibility.
- Physical Appearance.
- Adequacy of Waiting and Examining Room Space.

Physical Accessibility

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

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

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

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Bloodborne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

E. Monitoring for Compliance with Standards

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

Quality Improvement Activities and Programs

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

Health Management and Care Management

The Molina Health Management and Care Management Programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please refer to the Health Management and Care Management headings in the Health Care Services section of this Provider Manual.

F. Clinical Practice and Preventive Health Guidelines

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPGs) to reduce inter- Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority.

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
- HIV/AIDS
- Hypertension
- Obesity
- Opioid Management

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

All clinical practice guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, clinical practice guidelines are distributed to Providers at MolinaHealthcare.com/OhioProviders (or when changes are made during the year) and the Provider Manual. Notification of the availability of the clinical practice guidelines is published in the Molina Provider Newsletter.

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 (U.S. Preventive Services Task Force).
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics).
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States. These recommendations are revised every year by the Centers for Disease Control and Prevention.

All preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com/OhioProviders (or when changes are made during the year) and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Culturally and Linguistically Appropriate Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the Culturally and Linguistically Appropriate Services section of this Provider Manual.

G. Measurement of Clinical and Service Quality

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

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Behavioral Health Satisfaction Assessment
- Medicare Members Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Activities

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

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

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

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, obstetric and gynecological health screening, diabetes care, well check-ups, medication use and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on

established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

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

Behavioral Health Satisfaction Assessment

Molina obtains feedback from Members about their experience, needs, and perceptions of accessing behavioral health care services. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, among other areas.

Medicare Health Outcomes Survey (HOS)

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

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods used to identify improvement areas pertaining to the Molina Provider

network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

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

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

What Can Providers Do?

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

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® Star Ratings measures, contact your local Molina Quality Department.

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XIII. Compliance

A. Fraud, Waste, and 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 and detection 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 detect, deter and prevent 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

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

Regulatory Requirements

- **Federal False Claims Act**

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

  The term "knowing" is defined to mean that a person with respect to information:
  - Has actual knowledge of falsity of information in the Claim;
  - Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,
  - Acts in reckless disregard of the truth or falsity of the information in a Claim.

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

- **Deficit Reduction Act**

  The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.
  As a contractor doing business with Molina, Providers and their staff have the same obligation to report any actual or suspected violation fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:
  - The Federal False Claims Act and state laws pertaining to submitting false Claims
  - How Providers will detect and prevent fraud, waste, and abuse
  - Employee protection rights as whistleblowers

These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.
Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in 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 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 (AKS) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKS?

AKS 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 "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS 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 – The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. "Designated health services" are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

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 themselves 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 resulting 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.
- 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 Claims and Claims System

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

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

Molina 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

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under law and equity, or some combination thereof.

Provider will provide Molina, 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 with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Molina Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse, Provider agrees 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 164.501). 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.

B. 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 pre and post-payment billing audits. Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. 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 reserves the right and where unprohibited by regulation, to select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Molina paid in error. The estimated proportion, or error rate, may be extrapolated 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, Molina may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Molina reserves the right to recover the full amount paid or due to you.

Provider Education

When Molina 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.

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, 7 days a week, 365 days a year.

When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina 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 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 Ohio
Attn: Compliance Officer
PO Box 349020
3000 Corporate Exchange Drive
Columbus, OH 43234

Remember to include the following information when reporting:

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

MyCare Ohio Medicaid Fraud, Waste and Abuse:

Suspected fraud, waste, and abuse may also be reported directly to the state. If you suspect that a Medicaid recipient has committed fraud or abuse and would like to report it, please contact the County Department of Job and Family Services (CDJFS) in which the beneficiary resides. The number can be found in the CDJFS directory at jfs.ohio.gov/county/county_directory.pdf or in the telephone book under "County Government." If you are unable

to locate the number, please call the Ohio Department of Job and Family Services General Information Customer Service number at (877) 852-0010 for assistance.
Additional reporting may be made to the following state entities:

Ohio Department of Medicaid (ODM) (614) 466-0722 or at medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud

Office of the Ohio Attorney General, Medicaid Fraud Control Unit (MFCU) (800) 642-2873 or at medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud
ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud

Ohio Department of Job and Family Services (614) 752-3222 or at jfs.ohio.gov/fraud/index.stm

The Ohio Auditor of State (AOS) (866) FRAUD-OH or by email at fraudohio@ohioauditor.gov

If you suspect a Provider to have committed fraud or abuse of the Medicaid program, or have specific knowledge of corrupt or deceptive practices by a Provider, you should contact the Ohio Attorney General's Medicaid Fraud Control Unit at (614) 466-0722 or the Attorney General's Help Center at (800) 282-0515.

MyCare Ohio Medicare Fraud, Waste and Abuse:

CMS Toll Free Phone: 1-800-MEDICARE (1-800-633-4227), or

Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Toll Free Phone: (800) 447-8477
TTY/TDD: (800) 377-4950
Fax (10 page max): (800) 223-8164

Online at the Health and Human Services Office of the Inspector General Website:
oig.hhs.gov/FRAUD/REPORT-FRAUD/INDEX.ASP

XIV. Managed Long-Term Services and Support (MLTSS)

MLTSS Overview

MLTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS). Long-Term Care programs are when an individual is living in a facility-based care setting (such as a nursing home or intermediate care facility). Home and community-based services programs provide alternatives to living in facility-based care settings. These programs empower consumers to take an active role in their health care and to remain in the community. Both programs serve people who are older adults, people with intellectual and/or developmental disabilities, or people with physical disabilities.

Molina understands the importance of working with local Providers and Community Based Organizations (CBOs) to ensure Members receive MLTSS services that maintain their independence and ability to remain in the community.

Molina's MLTSS Provider network is a critical component to ensuring Members receive the right care, in the right place, at the right time. The following information has been included to help support our MLTSS Provider network and achieve a successful partnership in serving those in need. Information included in this Provider Manual applies to Molina's Independent Provider LTSS Network. For supplemental information for Independent Providers, visit the Independent Providers page on the Molina provider website.

MLTSS Services and Molina

Molina serves the following counties in the MyCare Ohio Program as of Jan. 1, 2026: Franklin, Delaware, Union, Madison, Pickaway, Clark, Greene, Montgomery, Clinton, Warren, Butler, Hamilton, Clermont, Columbiana, Cuyahoga, Fulton, Geauga, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Stark, Summit, Trumbull, Wayne and Wood. Please review the map at the beginning of this Provider Manual to learn the timeline for Wave 2 roll out to the rest of Ohio's counties.

Nursing Facility-Based (NF-Based) Level of Care (LOC)

MLTSS Services require a NF-Based LOC. This LOC includes the Intermediate and Skilled LOC:

- **Intermediate LOC** includes a need for assistance with activities of daily living, medication administration and/or a need for at least one skilled nursing or skilled rehabilitation service.
- **Skilled LOC** indicates a higher level of need than the Intermediate LOC and includes presence of an unstable medical condition and a need for a specific amount of skilled nursing or skilled rehabilitation services.

A Member must meet NF-Based LOC to receive long-term care services in a nursing facility or to enroll on the MyCare Waiver.

The **MyCare Waiver,** also known as the **MyCare Ohio HCBS Waiver** program encompasses the services offered under the Ohio Home Care, PASSPORT and Assisted Living Waivers, and is designed to help meet the needs of people who are:

- Financially eligible for Medicaid.
- Enrolled in the MyCare Ohio program.
- Have been assessed to require an Intermediate or Skilled LOC.
- Are age 21 or older.

Note: A person may not be eligible for the Ohio Department of Aging (ODA) and ODM administered HCBS Waivers if receiving, or qualify for, developmental disabilities (DD) waiver services.

MLTSS Benefits and Approved Services

Ohio Administrative Code (OAC) 5160-58-04 MyCare Ohio waiver: covered services and providers:

- Adult day health services as set forth in rule 173-39-02.1 or 5160-46-04
- Alternative meal services as set forth in rule 173-39-02.2
- Assisted living services as set forth in rule 173-39-02.16
- Choices home care attendant services as set forth in rule 173-39-02.4
- Community integration services as set forth in rule 173-39-02.15 or 5160-44-14
- Community transition services as set forth in rule 173-39-02.17 or 5160-44-26
- Enhanced community living services as set forth in rule 173-39-02.20
- Homemaker services as set forth in rule 173-39-02.8
- Home care attendant services as set forth in rule 173-39-02.24 or 5160-44-27
- Home-delivered meal services as set forth in rule 173-39-02.14 or 5160-44-11
- Home maintenance and chore services as set forth in rule 173-39-02.5 or 5160-44-12
- Home medical equipment and supplemental adaptive and assistive devices services as set forth in rule 173-39-02.7 or 5160-46-04
- Home modification services as set forth in rule 173-39-02.5 or 5160-44-13
- Nutrition consultation services as set forth in rule 173-39-02.10
- Out-of-home respite services as set forth in rule 173-39-02.23 or 5160-44-17
- Personal care aide services as set forth in rule 173-39-02.11 or 5160-46-04
- Personal emergency response services as set forth in rule 173-39-02.6 or 5160-44-16
- Structured Family Caregiving Service as set forth in rule 5160-44-33
- Social work counseling services as set forth in rule 173-39-02.12
- Waiver nursing services as set forth in rule 173-39-02.22 or 5160-44-22
- Waiver transportation services as set forth in rules 173-39-02.18 and 173-39-02.18 or 5160-46-04

Getting Care, Getting Started

The Area Agency on Aging (AAA) determines a Member's level of care for the MyCare Waiver. When a client contacts the AAA or a referral is completed by a Molina Care Coordinator for the MyCare Waiver, an intake coordinator will assess the need and provide the resources the

Member is requesting and is eligible to receive. The intake coordinator will schedule a Level of Care Assessment – ACAT (Adult Comprehensive Assessment Tool) to be completed with the Member.

NOTE: Ohio has 12 AAAs that collectively represent all 88 counties. Ohio AAAs are designated by the ODA.

The AAA office that is designated for each of the counties represented in the Molina Complete Care for MyCare Ohio plan are:

- **Central Ohio Area Agency on Aging (COAAA), AAA6**
  Serving: Delaware, Franklin, Madison, Pickaway and Union counties
  Phone: (614) 645-7250
  Address: 3776 South High Street
  Columbus, OH 43207
- **Council on Aging of Southwestern Ohio (COA), AAA1**
  Serving: Butler, Clermont, Clinton, Hamilton and Warren counties
  Phone: (513) 721-1025
  Address: 4601 Malsbary Road
  Blue Ash, OH 45242
- **Area Agency on Aging for West Central Ohio, AAA2**
  Serving: Clark, Greene and Montgomery counties
  Phone: (937) 223-4357
  Address: 40 W. Second Street, Suite 400
  Dayton, OH 45402
- **Area Office on Aging of Northwestern Ohio, AAA4**
  Serving: Erie, Fulton, Henry, Lucas, Ottawa, Paulding, Sandusky, Williams and Wood counties
  Phone: (419) 382-0624
  Address: 2155 Arlington Ave.
  Toledo, OH 43609-0624
- **Western Reserve Area Agency on Aging, AAA10A**
  Serving: Cuyahoga, Geauga, Lake, Lorain and Medina counties
  Phone: (216) 621-8010
  Address: 1700 East 13th St., Suite 114
  Cleveland, OH 44114
- **Direction Home Akron Canton Area Agency on Aging, AAA10B**
  Serving: Portage, Stark, Summit and Wayne Counties
  Phone: (330) 896-9172
  Address: 1949 Town Park Blvd.
  Uniontown, OH 44685
- **Direction Home of Eastern Ohio, AAA11**

Serving: Ashtabula, Columbiana, Mahoning and Trumbull Counties
Phone: (330) 505-2300
Address: 1030 N. Meridian Rd.
Youngstown, OH 44509

- **Area Agency on Aging 3, Inc., AAA3**
  Serving: Allen, Auglaize, Hancock, Hardin, Mercer, Putnam and Van Wert counties
  Phone: (419) 222-7723
  Address: 2423 Allentown Road
  Lima, OH 45805
- **Ohio District 5 Area Agency on Aging, AAA5**
  Serving: Ashland, Crawford, Huron, Knox, Marion, Morrow, Richland, Seneca and Wyandot counties
  Phone: (419) 524-4144
  Address: 2131 Park Avenue West
  Ontario, OH 44906
- **Area Agency on Aging, District 7, AAA7**
  Serving: Adams, Brown, Gallia, Highland, Jackson, Lawrence, Pike, Ross, Scioto and Vinton counties
  Phone: (740) 245-5306
  Address: 1 Acy Avenue
  Jackson, OH 45640
- **Buckeye Hills Regional Council, AAA8**
  Serving: Athens, Hocking, Meigs, Monroe, Morgan, Noble, Perry and Washington counties
  Phone: (740) 373-6400
  Address: 1400 Pike Street
  Marietta, OH 45750
- **Area Agency on Aging Region 9, AAA9**
  Serving: Belmont, Carroll, Coshocton, Guernsey, Harrison, Holmes, Jefferson, Muskingum and Tuscarawas counties
  Phone: (740) 439-4478
  Address: 710 Wheeling Avenue
  Cambridge, OH 43725

Molina contracts with the Area Agency on Aging (AAA) to provide waiver service coordination for Members aged 60 and older. Members aged 60 and over may select their Waiver Service Coordinator entity as either the AAA or Molina. If the Member is age 59 and younger, Molina will automatically be the Waiver Service Coordinator. The Care Coordinator and Waiver Service Coordinator may be the same individual.

The Molina Care Coordinator and Waiver Service Coordinator will engage with Members and routinely assess opportunities and barriers to coordinate medical, behavioral health and MLTSS services. Specifically, along with providing the Person-Centered Care Plan (PCSP), the Care

Coordinator and Waiver Service Coordinator provide verbal, written and/or alternate format information on:

- After-hours assistance for urgent situations.
- Access to timely appointments.
- Accommodations available to meet individual linguistic, literacy, and preferred modes of communication.
- Advocacy, engagement of family Members and informal supports.

At a minimum, the Care Coordinator and Waiver Service Coordinator names, contact information is included in the Person-Centered Care Plan, which is shared with all Interdisciplinary Care Team (ICT) participants based on a Member's recorded preferences. All Care Coordinators and Waiver Service Coordinators are required to keep email and voicemail current with availability or backup as necessary for Members and their Providers.

Molina will ensure the provision of the following service coordination services for the Members:

- MLTSS Waiver Service Coordination/Care Management
- PCSP Review
- Crisis Intervention
- Event Based Visits
- Long Term Facility-based Visits
- Service Management
- Medicaid Resolution
- Assessment of MLTSS Need
- Member Education

After the Member's needs have been determined, Molina will work closely with the various Community-Based Organizations (CBOs) for Home and Community-Based Services (HCBS) to ensure that the Member is getting the care that they need.

Once you have been identified as the Provider of service, it will be your responsibility for billing of these services. The PCSP will document services, duration and any other applicable information.

Care Management/ICT

All Members enrolled in MyCare Ohio will receive Care Management and be assigned a Care Coordinator from Molina.

The Care Management team for MLTSS will include, at a minimum, the Member and/or their authorized representative, Care Coordinator, Waiver Service Coordinator and Primary Care Provider (PCP).

The person-centered ICT will include, at minimum, the Member and/or their authorized representative, the PCP, the Care Coordinator, the Waiver Service Coordinator and anyone the Member requests to participate. ICT members may also include MLTSS Providers (e.g. Services Facilitator, Adult Day Health Care Center staff, transition coordinator, Nursing Facility staff, etc.), specialist(s), behavioral health clinician and pharmacist. The ICT can also include family/caregivers, peer supports, or other informal supports and is not limited to the list of required members.

Person-Centered Care Plan Coordination

MLTSS services to be covered by Molina will require coordination and approval.

The PCCP includes the consideration of medical, behavioral, and long-term care needs of the Member identified through a person-centered assessment process. The PCCP includes informal care, such as family and community support. Molina will ensure that a PCCP is implemented for the Member in compliance with the Department of Health and Human Services HCBS final rule section 441.301.

A PCCP refers to the plan that documents the amount, duration and scope of the home and community-based services. The Person-Centered Care Plan must reflect the services and supports important for the individual Member to meet their needs, goals and preferences which are identified through assessment of Member need. The service plan will also identify what is important regarding the delivery of these services and supports (42 CFR 441.725). Providers responsible for implementing services on the PCCP will be asked to sign or attest to the services they will provide (42 CRF 441.725).

The PCCP will be developed under the Member's direction and implemented by the assigned Members of the ICT no later than the end date of any existing Service Authorization or within the state-specific timeframes for initial assessments and reassessments. This applies to the MyCare Waiver. All services and changes to services must be documented in the PCCP and be under the direction of the Member in conjunction with the Care Coordinator and Waiver Service Coordinator.

The ICT under Member's direction is responsible for developing the PCCP and is driven by and customizable according to the needs and preferences of the Member. As a Provider you may be asked to be part of the ICT.

Additional services can be requested through the Member's Care Coordinator and Waiver Service Coordinator at any time; including during the assessment process and through the ICT process. Additional services needed must be at the Member's direction and can be brought forward by the Member, the Care Coordinator, and/or the ICT as necessary. Once an additional need is established, the PCCP will be updated with the Member's consent and additional services approved.

Transition of Care Programs, Policies and Requirements

Molina has processes and systems in place to ensure smooth transitions between each Member's setting of care and level of care. This includes transitions to and from inpatient settings (i.e. Nursing Facility to Home).

All Care Coordinators and Waiver Service Coordinators are trained on the transitions of care approach that Molina follows for transitions between care settings. The care coordinators facilitate on-site, in-person, and home-based assessments that are housed in an electronic health management platform.

Continuity of Care (COC) Policy and Requirements

Molina will prompt safe transition of Members while adhering to minimal service disruption. In order to minimize service disruption, Molina will honor the Member's existing services at the time of enrollment in the MyCare program from the first date of enrollment for the time periods listed below. For the Assisted Living Waiver Service, the Provider will be maintained at current Medicaid rate. Direct Care Waiver Services will maintain service at current level and with current Providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01, the Member expresses a desire to self-direct services, or after 180 days. All other Waiver Services will maintain service at current level for 180 days and existing service Provider at existing rate for 90 days. Plan initiated change in service Provider can only occur after the completion of an in-home assessment and plan for the transition to a new Provider.

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health (HH) and Private Duty Nurse (PDN) use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not identified for LTSS
Physician	180 days	180 days	180 days	180 days
Durable Medical Equipment	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity
Scheduled Surgeries	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized	Treatment initiated prior to enrollment must be authorized through the course	Treatment initiated prior to enrollment must be authorized through the course of	Treatment initiated prior to enrollment must be authorized through the course

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health (HH) and Private Duty Nurse (PDN) use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not identified for LTSS
	through the course of treatment with the specified provider	of treatment with the specified provider	treatment with the specified provider	of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Dialysis Treatment	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider
Vision and Dental	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered	Must honor PAs when item has not been delivered
Medicaid HH and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates; Changes may not occur unless: 1) A significant change occurs as defined in OAC 5160-45-01, or 2) member expresses a desire to self-direct services, or after 180 days	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health (HH) and Private Duty Nurse (PDN) use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not identified for LTSS
Assisted Living Waiver Service			Provider maintained at current Medicaid rate	
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate	
Waiver Services - Direct Care Personal Care Waiver Nursing Home Care Attendant Choice Home Care Attendant Out of Home Respite Enhanced Community Living Adult Day Health Services Social Work Counseling Independent Living Assistance	Maintain service at current level and with current providers at current Medicaid reimbursement rates. MCOP initiated changes may not occur unless: A significant change occurs as defined in OAC 5160-45-01; or member expresses a desire to self-direct services, or after 180 days	N/A	N/A	N/A
Waiver Services – All other	Maintain service at current level for 180 days and existing service provider at existing rate for 90 days; MCOP initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider	N/A	N/A	N/A
Medicaid Community Behavioral Health (BH) Organizations	Maintain current provider, level of services documented in	Maintain current provider, level of services documented in the BH plan of care	Maintain current provider, level of services documented in the BH plan of care at	Maintain current provider, level of services documented in the

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health (HH) and Private Duty Nurse (PDN) use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not identified for LTSS
(Provider types 84 & 95)	the BH plan of care at the time of enrollment for 180 days; Medicaid rate applies during transition	at the time of enrollment for 180 days; Medicaid rate applies during transition	the time of enrollment for 180 days; Medicaid rate applies during transition	BH plan of care at the time of enrollment for 180 days; Medicaid rate applies during transition
Pregnancy-Related Services	Allow an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital	Allow an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital	Allow an out-of-network provider if the member is in her third trimester of pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital	Allow an out-of-network provider if the member is in her third trimester of Pregnancy and/or has an established relationship with an obstetrician and/or delivery hospital
SRS	N/A	Maintain service at current level and with current providers at current Medicaid reimbursement rates for 180 days after initial enrollment	N/A	Maintain service at current level and with current providers at current Medicaid reimbursement rates for 180 days after initial enrollment
OhioRISE	N/A	Maintain current provider and level of services currently received at the time of enrollment for at least 45 days regardless of whether the authorized or treating provider is a network or out-of-network provider. OhioRISE rates apply during transition	N/A	Maintain current provider and level of services currently received at the time of enrollment for at least 45 days regardless of whether the authorized or treating provider is a network or out-of-network provider. OhioRISE rates apply during transition

If the member has a FFS or MCO prior authorization approved prior to the member's transition:

- Molina must honor the prior authorization through the expiration of the authorization, regardless of whether the authorized or treating provider is a network or out-of-network.
- Molina may conduct a medical necessity review for previously authorized services if the member's needs change to warrant a change in service. The MCOP must render an authorization decision pursuant to OAC rule 5160-26-03.1.
- Molina may assist the member to access services through a network provider when any of the following occur:
    - The member's condition stabilizes and Molina can ensure no interruption to services;
    - The member chooses to change the member's current provider to a network provider; or
    - If there are quality concerns identified with the previously authorized provider.

Upon notification from a member or provider of a need to continue services, Molina must allow a new member to continue to receive services from network and out-of-network providers when the member could suffer detriment to their health or be at risk for hospitalization or institutionalization in the absence of continued services.

Exceptions

During the transition period, change from the existing services, or Provider, can occur in any of the following circumstances:

- Member requests a change.
- Significant change in Member's status.
- Provider gives appropriate notice of intent to discontinue services to a Member.
- Provider performance issues are identified that affect a Member's health and welfare.

Plan-initiated change in a service Provider can only occur after the completion of an in-home assessment and development of a plan for the transition to a new Provider.

During the Transition Period

Existing Providers can continue to serve current Members who transition to MyCare Ohio. Providers will be working directly with participating MyCare Ohio Plans (MCOPs).

- At the time of enrollment, any additional services needed by the Member that are not already on the Member's person-centered care plan must be authorized by the MCOP.
- MCOPs will have their own processes for the approval of waiver services.
- A contract with the MCOP is not necessary during the transition period. MCOPs will reach

out to Providers.
- Existing Providers must make authorization and payment arrangements directly with the MCOP. Contact the MCOP to make arrangements.

Ongoing Provider support and technical assistance will be provided; especially to community behavioral health, MLTSS Providers, and out-of-network Providers during the continuity of care period. All existing ICPs and Service Authorizations (SAs) will be honored during the transition period.

A Member's existing Provider may be changed during the transition period only in the following circumstances: (1) the Member requests a change; (2) the Provider chooses to discontinue providing services to a Member as currently allowed by Medicaid; (3) Molina or ODM identify Provider performance issues that affect a Member's health or welfare; or (4) the Provider is excluded under state or federal exclusion requirements.

Out-of-network Providers who are providing services to Members during the initial continuity of care period shall be contacted to offer information on how to become credentialed, in-network Providers with Molina. If the Provider chooses not to join the network, or the Member does not select a new in-network Provider by the end of the transition period, Molina will work with the Member in selecting an in-network Provider.

Members in a Nursing Facility at the time of Molina MLTSS enrollment may remain in that NF as long as the Member continues to meet nursing facility level of care, unless they or their family or authorized representative prefer to move to a different Nursing Facility or return to the community. The only reasons for which Molina may require a change in Nursing Facility is if (1) Molina or ODM identify Provider performance issues that affect a Member's health or welfare; or (2) the Provider is excluded under state or federal exclusion requirements.

For additional information regarding continuity of care and transition of MLTSS Members, please contact Molina at (855) 322-4079.

Self-Directed Care Services

Members have the choice of how their services are delivered through various models, which may include self-direction.

In a self-directed model, the state requires Molina maintain a contract with Public Partnerships (PPL) to serve as this financial management agency, also known as a fiscal intermediary. PPL will work with Members to handle the taxes, payroll and worker's compensation responsibilities of being an employer.

Per OAC 5160-58-04 MyCare Ohio waiver: covered services and Providers, paragraph (F), the following services may be participant-directed using budget and/or employer authority. To

exercise these authorities, Members must demonstrate the ability to direct Providers in accordance with paragraph (D) of rule 5160-58-03.2 of the Administrative Code:

1. Employer authority which includes, but is not limited to, the ability of the Member to hire, fire and train employees is available for the following services:
   a. Choices Home Care Attendant
   b. Home Care Attendant
   c. Personal Care Aide
   d. Waiver Nursing
2. Budget authority which includes the ability of the Member to negotiate rates of reimbursement is available in the following services:
   a. Alternative Meals
   b. Choices Home Care Attendant
   c. Home Care Attendant
   d. Home Medical Equipment
   e. Home Modifications
   f. Personal Care Aide
   g. Self-Directed Goods and Services
   h. Waiver Nursing

Self-directed services mean that participating Members or their representatives have decision-making authority over certain services and manage their services with supports, such as those provided by Public Partnerships (PPL). Self-directed services give Members and their families more flexibility, control and responsibility for managing all aspects of the Member's care.

A Waiver Care Coordinator will provide oversight to assist the Member with self-directed services. The Member also may choose an authorized representative to help with the day-to-day supervision of their service Provider and to assist with employer-related tasks.

All Member-directed personal care Providers are required to meet established training requirements, and to undergo criminal background checks prior to working for a PASSPORT Waiver Member.

When a Member is already participating in self-directed care through a Medicaid waiver prior to enrolling in the MyCare Ohio HCBS Waiver, the current Provider with the same services, frequency and rates will remain for up to 180 days unless any of the following happens:

- There is no longer an assessed need for one of the services.
- The authorized representative is no longer able to fulfill the responsibilities of Member.
- There is no longer an authorized representative, if required.
- The health and well-being of the Member is affected, as determined by the waiver service coordinator.

Waiver Provider Signature Requirement

Waiver service Providers for the Assisted Living, MyCare, Ohio Home Care and PASSPORT waivers (collectively known as the Next Generation MyCare Waiver) are required to sign the Member's person-centered care plan in order to meet Centers for Medicare and Medicaid Services (CMS) 42 CFR 441.301 rule and ODM requirements. The Provider's signature shows that the Provider acknowledges and agrees to provide the waiver service, as authorized in the person-centered care plan.

Providers who are affected by this requirement include those who are delivering "direct care" services including:

- Personal care
- Waiver nursing
- Home care attendant
- Out-of-home respite
- Enhanced community living
- Adult day services
- Social work counseling
- Independent living assistance

The direct care Provider's signature will be required when:

- The Provider receives a waiver service authorization for a new service.
- The waiver service authorization reflects a permanent change to a previously authorized service.

Credentialing and Contracting

Credentialing of MLTSS Providers is performed by the applicable AAA and contracting is performed by Molina. Molina is required to contract only with Providers who have been approved by the Ohio Department of Aging to perform a particular waiver service or set of services. Reminder: ODM is responsible for credentialing all Medicaid and MyCare Ohio-managed care providers. Providers are not able to render services to Medicaid members until they are fully screened, enrolled and credentialed by Ohio Medicaid. See the Credentialing and Recredentialing section of this Provider Manual for additional information.

The regional AAAs determine if the organization wanting to provide waiver services has the capacity to meet all of the Conditions of Participation (OAC 173-39-02) and relevant Service Specifications (OAC 173-39-02.1 through 173-39-02.17). The Provider Relations Division of the AAA agency, which is charged with certifying and monitoring Providers, operates with a quality improvement approach. To determine capacity, the agency's Quality Improvement (QI) coordinators examine the Provider applicant's policies and procedures, documentation system, charting processes and delivery of direct Member services.

Who can apply to become an Ohio Department of Aging (ODA)-certified agency Provider?

Applicants must be legal businesses (either not-for-profit or for-profit) within the State of Ohio. All applicants must have provided, at the time of application, services to individuals aged 60 years or older in Ohio for a minimum of three months. The applicant must employ qualified staff and have written policies and procedures that support the Conditions of Participation and Service Specifications, as described below. Visit Certification Information | Department of Aging for more information.

What are the Conditions of Participation and Service Specifications?

ODA, in consultation with ODM, the regional AAAs and service Providers, established the Conditions of Participation and Service Specifications as the standards by which all services must be delivered. They were designed to ensure the health, safety and welfare of each Member.

The Conditions of Participation (OAC 173-39-02) apply to all service Providers.
The Service Specifications (OAC 173-39-02.1 through 173-39-2.17) define and set the standards for individual PASSPORT services and apply only to Providers of those services.

There are no exceptions or waivers to the Conditions of Participation or Service Specifications, regardless of the size or the mission of the organization.

What does it mean to be a contracted Provider?

- Allows you to be published as a contracted Provider of the MCOP (Provider Directory, plan website, Medicaid Consumer Hotline).
- Establishes rate(s) of payment for your services and facilitates Molina's payment of claims.

Certification

As a condition of participation with Molina, a Provider must acquire and maintain ODM certification for the services it provides. If a Provider loses certification, immediate termination of the contract may result.

Loss of Certification/Contract termination process

If a Provider is no longer able to provide the approved services, the Provider must contact the Member's waiver service coordinator.

If a Provider is contracted with Molina for both medical and MLTSS services and wishes to discontinue the provision of MLTSS services and only provide medical services, the Provider must contact the Molina Contracting Department to update their specialty profile.

If a Provider wishes to terminate their contract, or if termination is required because the Provider has lost certifications, the Provider must contact Molina immediately.

Bidding Process

A bidding process will occur when there is a waiver service with no fee published on the Ohio Medicaid fee schedule. Molina has set fees for most services. If a service is needed for which Molina does not have a set fee, Molina will reach out to all appropriate Providers to request a bid.

Home Maintenance and Chore Services, Transportation, Home Modification, Home Medical Equipment and Supplemental Adaptive and Assistive Devices require bids.

Provider Compliance Oversight

Structural Compliance Reviews (SCR) will be conducted by either Public Consulting Group (PCG) or the PASSPORT Administrative Agency (PAA).

Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid Waiver(s) for which they are certified/approved.

Each entity that pays claims, including Molina, will review Providers' documentation to verify that services authorized and paid for are actually provided.

Provider Complaints:

- Provider should work directly with Molina to resolve the issue.
- If the issue is not resolved, the Provider may submit a complaint to ODM at providercomplaints.ohiomh.com.
- For certification issues, the Provider should work with AAA or ODM to resolve.

Appeals, Grievances and State Hearings

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

Molina ensures that Members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed Members are informed of their appeal and grievance rights and the process in the Member Handbook.

Member Grievances

For information on Member Grievances, read the Appeals and Grievances section of this Provider Manual.

Member Appeals

For information on Member Appeals, read the Appeals and Grievances section of this Provider Manual.

Member's Right to a State Fair Hearing

For information on a Member's Right to a State Fair Hearing, read the Appeals and Grievances section of this Provider Manual.

Ombudsman

Long-term Care Ombudsmen safeguard Members who receive care services, advocating for quality care, investigating complaints and giving Members a voice.

Ombudsmen field complaints about long-term care services, voice Members' needs and concerns to nursing homes, home health agencies and other Providers of long-term care. While they do not "police" nursing homes and home health agencies, they work with the long-term care Provider and the Member, the Member's family or other representatives to resolve problems and concerns the Member or their representative may have about the quality of services received.

Ombudsmen link the Member with the services or agencies they need to live a more productive, fulfilling life. Ombudsmen advise the Member on selecting long-term care in Ohio, inform the Member about their rights and provide information, as well as assist with benefits and insurance.

Refer to the Regional Long-Term Care Regional Long-Term Care Ombudsman map to contact the Ombudsman for a specific region.

Provider Claims Dispute (Adjustment Request)

For more information on Provider claims disputes, read the "Claim Reconsideration Request (Dispute)" section of this Provider Manual.

Molina's Right to Verify Waiver Services Rendered

Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid Waiver(s) for which they are certified/approved. Each entity that pays claims will review the Provider's documentation to verify that services authorized and paid for are actually provided.

Incident and Provider Occurrences Reporting and Management

Molina participates in efforts to prevent, detect and remediate incidents and provider occurrences, based on requirements for home and community-based waiver programs.

It is important that our Providers report any activities that seem out of the norm. It is imperative that we ensure Members are protected and safe from harm. Incidents and provider occurrences that occur in a Nursing Facility, inpatient behavioral health or home-and community-based service delivery setting (e.g., an adult day health care center, a Member's home or any other community-based setting), among other settings will be reported in a timely manner.

For additional information, review OAC 5160-44-05 Nursing facility-based level of care home, community-based services (HCBS) programs and specialized recovery services (SRS) program: incident management, or read the Reporting of Suspected Abuse and/or Neglect section under Health Care Services in this Provider Manual.

If you suspect neglect and/or abuse, please contact the waiver service coordinator and/or the appropriate authority dependent upon the nature of the incident.

Fighting Fraud, Waste and Abuse

Molina of Ohio maintains a comprehensive fraud, waste and abuse program.
For more information on fighting fraud, waste and abuse, read the Fraud, Waste and Abuse Program section of this Provider Manual.

Claims for MLTSS Services

Providers must submit Claims electronically via the Ohio Department of Medicaid Ohio Medicaid Enterprise System (OMES) through EDI or direct data entry claims via the Availity Essentials portal.

To register please visit: availity.com/providers/.

For information on how to submit a claim via the Availity Essentials portal contact the health plan Provider Services Team at (855) 322-4079.

Electronic Visit Verification (EVV)

ODM implemented Electronic Visit Verification (EVV) for some home and community-based services in response to federal requirements set forth in section 12006 of the H.R. 34 (114th Congress) (2015-2016) of the 21st Century Cures Act.

To learn more visit the ODM EVV Homepage.

Billing Molina

For more information on billing Molina, read the Claim Submission section of this Provider Manual.

Atypical Providers

Atypical Providers are service Providers that do not meet the definition of health care Provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation and respite services, etc. Although they are not required to register for an NPI, these Providers perform services that are reimbursed by Molina.

Atypical Providers are required to use the Ohio Medicaid ID given to them by the State of Ohio to take the place of the NPI. As long as the Provider submits the Claim with the Medicaid ID number, the Claim will not be rejected back to the Provider for missing information.

NOTE: When billing Molina for MLTSS Services, the HCPC Code and Modifier Description Guide can be used to locate the proper billable codes. A numerical version of the guide is in the Appendix section of this manual.

Claims Submission: Availity Essentials Portal

Our MLTSS Providers must utilize the Availity Essentials portal to submit claims. Please see the Electronic Claim Submission section under Claims and Encounter Data in this Provider Manual. You may also contact your Provider Services Team for additional information at (855) 322-4079.

Timely Claim Filing

For more information on Timely Filing, read the Timely Claim Filing section under Claims Information in this Provider Manual.

Timely Claim Processing

For more information on timely claim processing, read the Timely Claim Processing section under Claims Information in this Provider Manual.

Billing Molina Members

Balanced Billing of a Medicaid recipient is prohibited by law. For more information on Billing Molina Members, read the Billing Molina Healthcare Members section under Claims Information in this Provider Manual.

Patient Liability

For more information on Patient Liability, read the Patient Liability section under Claims Information in this Provider Manual.

HCPC Code and Modifier Description

For additional information see the LTSS Waiver Billing Guidelines on our Provider Website, under the "Manual" tab, on the "Quick Reference Guides & FAQs" page.

Nursing Facility Billing Guidance

Find additional Nursing Facility Billing Guidance in the Nursing Facilities Orientation.

XV. MyCare Ohio: Medicaid Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high quality, cost effective drug therapy.

Molina works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases in alignment with the ODM Unified Preferred Drug List page for Part D and Medicaid covered drugs. Molina covers prescription and certain over-the-counter drugs.

Pharmacy and Therapeutics Committee

The National Pharmacy and Therapeutics Committee (P&T) meets quarterly to review and recommend medications for formulary consideration. The P&T Committee is organized to assist Molina with managing pharmacy resources and to improve the overall satisfaction of Molina Members and Providers. It seeks to ensure Molina Members receive appropriate and necessary medications. An annual pharmacy work plan governs all the activities of the committee. The committee's voting membership consists of external physicians and pharmacists from various clinical specialties.

Pharmacy Network

Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (855) 322-4079.

Medications Not Covered

Medications not covered by Medicaid are excluded from coverage. For example, drugs used in the treatment of infertility or those used for cosmetic purposes are not part of the benefit.

Member and Provider "Patient Safety Notifications"

Molina has a process to notify Members and Providers regarding a variety of safety issues which include voluntary recalls, FDA required recalls and drug withdrawals for patient safety reasons. This is also a requirement as an NCQA accredited organization.

XVI. MyCare Ohio: Medicare Part D

A. Coverage Determinations

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a Unified Preferred Drug List exception request, a decision on the amount of cost sharing for a drug, or whether a Member has or has not satisfied a prior authorization or other UM requirement.

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

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

B. Appeals/Redeterminations

See the Member Appeal process of this Provider Manual.

C. Part D Prescription Drug Exception Policy

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

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

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

Molina's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D Exceptions and Appeals Contact Information: call Molina at (800) 665-3086 or fax (866) 290-1309.

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

Understanding Part D Prescription Drug Coverage

1. **Formulary** –Molina utilizes the ODM MyCare Ohio Unified Preferred Drug List. Molina will generally cover the drugs listed in our formulary as long as the drug is Medically Necessary, the prescription is filled at a Molina network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA approved or compendia supported for the diagnosis for which it is being used), and other plan rules are followed.

2. **Copayments for Part D** – The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.
   - Most Part D services have a copayment;
   - Co-payments cannot be waived by Molina per CMS; and,
   - Co-payments for Molina may differ by State and plan.

   - Consult the Molina Complete Care for MyCare Ohio Member Handbook on the Member Resources page for more details about Part D copayments.

3. **Restrictions on Molina's Medicare Drug Coverage –** Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:
   - **Prior Authorization**: Molina requires prior authorization for certain drugs, some of which are on the Unified Preferred Drug List and also drugs that are not on the formulary. Without prior approval, Molina may not cover the drug.
   - **Quantity Limits**: For certain drugs, Molina limits the amount of the drug that it will cover.
   - **Step Therapy**: In some cases, Molina requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, Molina may not cover Drug B unless Drug A is tried first.
   - **Part B Medications**: Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. Newly FDA approved drugs are considered non-formulary

and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

4. **Non-Covered Molina Medicare Part D Drugs**

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

5. **Requesting a Medicare Formulary Exception** –Medicare product drug prior authorizations are called Exceptions, which are required when your patient needs a drug that is not on the Unified Preferred Drug List. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an Exception. (The process for filing an Exception is predominantly a fax-based system.) The form for Exception requests is available on the Molina website.

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

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

- A standard appeal may be submitted to Molina in writing. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven calendar days from the date the request for re-determination is received.
- An expedited appeal can be requested by the Member or by a Provider acting on behalf of the Member in writing or can be taken over the phone. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the request for an expedited appeal, Molina will honor this request.
- If a Member submits an appeal without Provider support, Molina will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, Molina will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the expedited criteria, Molina will render a coverage decision within the standard redetermination time frame of seven calendar days.
- To submit a verbal request, please call (855) 665-4623 for English and Spanish, TTY: 711. Written appeals must be mailed or faxed to (563) 499-0610.

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

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

   a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
      - American Hospital Formulary Service Drug Information
      - DRUGDEX® Information System
   b. Requests for off-label use of medications will need to be accompanied with excerpts from one of the two CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.

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

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

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

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

8. **Initiating a Part D Appeal** – If Molina's initial coverage determination is unfavorable, a Member may request a first level of appeal, or re-determination within 60 calendar days from the date of the notice of the coverage determination. In a standard appeal, Molina has up to seven days to make the re-determination, whether favorable or adverse, and notify the Member in writing within seven calendar days from the date the request for re-determination is received. Members or a Member's prescribing Provider may request Molina to expedite a redetermination if the standard appeal timeframe of seven days may seriously jeopardize the Member's life, health, or ability to regain maximum function. Molina has up to 72 hours to make the re-determination, whether favorable or adverse, and notify the Member in writing within 72 hours after receiving the request for re-determination. If additional information is needed for Molina to make a re-determination, Molina will request the necessary information within 24 hours of the initial request for an expedited re-determination. Molina will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

9. **The Part D Independent Review Entity (IRE)** – If the re-determination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor is currently C2C, a CMS contractor that provides second level appeals.
   - Standard Appeal: The IRE has up to seven days to make the decision.
   - Expedited Appeal: The IRE has up to 72 hours to make the decision.

- Administrative Law Judge (ALJ): If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.
- Medicare Appeals Council (MAC): If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable on this level of appeal.
- Federal District Court (FDC) – If the MAC's decision is unfavorable, the Member may appeal to a federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.

XVII. Members' Rights and Responsibilities

Providers must cooperate with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website. The Member Handbook is provided to Members annually and is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link:

- MyCare Ohio dual benefits: Member Handbook
- MyCare Ohio Medicaid Only benefits: Member Handbook

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

For additional information, please contact Molina at (855) 322-4079, Monday through Friday from 8 a.m. to 8 p.m., TTY users, please call 711.

Second Opinions

If Members do not agree with their Providers' plan of care, they have the right to a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require prior authorization.

Open Access Health Care Services

Members must receive services covered by Molina from facilities and/or Providers on Molina's panel. Members may use Providers that are not on Molina's panel for the following services:

- Federally qualified health centers/rural health clinics
- Qualified family planning Providers
- Community mental health centers
- Ohio Department of Mental Health and Addiction Services (ODMHAS) facilities which are Medicaid Providers

- Emergency Services
- Services prior authorized by Molina

In addition, Molina Complete Care for MyCare Ohio Members have the right to:

- Request a State Fair Hearing by calling (800) 952-5253. Members also have the right to receive information on the reason for which an expedited State Fair Hearing is possible.
- Receive family planning services, treatment for any sexually transmitted disease and emergency care services from Federally Qualified Health Centers without receiving prior approval and authorization from Molina.

XVIII. Risk Adjustment Accuracy and Completeness

What is Risk Adjustment?

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

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

Your Role as a Provider

As a Provider complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. 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 the CMS National Correct Coding Initiative (NCCI).
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with the 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 physician's signature and credentials.

Interoperability

The Provider agrees to deliver relevant clinical documents Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format at encounter close for Molina Members by using one of the automated methods available and supported by Provider's Electronic Medical Records (EMR), including, but not limited to, Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The CDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging health care information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If Provider does not have Direct Address, Provider will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicaid Services (CMS) requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If the Provider's EMR does not support the Direct Protocol, Provider will work with Molina's established interoperability partner to get an account established.

Contact Information

For questions about Molina's Risk Adjustment Programs, please contact your Molina Provider Relations Team.

XIX. Delegation

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

1. Medical Management
2. Credentialing and Recredentialing (Medicaid and MyCare Ohio lines of business are excluded)
3. Claims Administration
4. Complex case management
5. Other clinical and administrative functions

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

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by Molina Delegation Oversight Staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

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

If you have additional questions related to delegated functions, please contact your Molina Provider Relations Team.