PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Michigan, Inc.

(Molina Healthcare or Molina)

Medicaid

2026

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Provider Agreement with Molina Healthcare. "Molina Healthcare" or "Molina" have the same meaning as "Health Plan" in your Provider 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.

Providers may request a printed copy of this manual by sending an email request to MHMProviderServicesMailbox@MolinaHealthcare.com.

Last Updated: September 2026

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INTRODUCTION

Molina Medicaid is the brand name of Molina Healthcare of Michigan, Inc.'s (Molina) Medicaid line of business.

Molina is licensed and approved by the Michigan Department of Health and Human Services (MDHHS) to operate in the following counties: Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Huron, Ionia, Iosco, Isabella, Kalkaska, Kent, Lake, Lapeer, Leelanau, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, St. Clair, Sanilac, Shiawassee, Tuscola, Wayne, and Wexford.

Molina Medicaid

Molina Medicaid is the name of Molina's Medicaid (HMO) Plan, which provides Medicaid and Prescription Drug Benefits. The Molina Medicaid HMO plan was designed for Members who are eligible for Medicaid under a managed care plan in order to provide quality health care coverage and service with no out-of-pocket costs. Molina Medicaid embraces Molina's long-standing mission to serve those who are the most in need and traditionally have faced barriers to quality health care.

Please contact the Member & Provider Services Contact Center toll free at (855) 322-4077, Monday through Friday, from 8:00 a.m. to 5:00 p.m. local time, with questions regarding this program. TTY/TDD users, please call 711.

Use of this Provider Manual

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

The Molina Provider website contains samples of the forms needed to fulfill your obligations under your Molina contract. If you are already using forms that accomplish the same goals, you may not need to modify them.

The Benefit of Experience

By focusing exclusively on serving low-income families and individuals who receive health care benefits through government-sponsored programs, Molina has developed strong relationships with Members, Providers and government agencies within each regional market that it serves. Molina's ability to deliver quality care, establish and maintain provider networks, and administer services efficiently has enabled it to compete successfully for government contracts.

Quality

Molina is committed to quality and has made accreditation a strategic goal for each health plan. Year after year, Molina health plans have received accreditation from the National Committee for Quality

Assurance (NCQA). The NCQA accreditation process sets the industry standard for quality in health plan operations.

Flexible Care Delivery Systems

Molina has constructed its systems for health care delivery to be readily adaptable to different markets and changing conditions. Health care services are arranged through contracts with Providers that include independent Providers, medical groups, hospitals and ancillary Providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates and diagnostic-related groups (DRG).

Cultural and Linguistic Expertise

National census data shows that the United States' population is becoming increasingly diverse. Molina has over 35 years of history developing targeted health care programs for a culturally diverse membership, and is well-positioned to successfully serve these growing populations by:

- Contracting with a diverse network of community-oriented Providers who have the capabilities to address the linguistic and cultural needs of Members
- Educating employees about the differing needs among Members
- Developing Member education material in a variety of media and languages and ensure the literacy level is appropriate for our target audience

CONTACT INFORMATION

Molina Healthcare of Michigan, Inc.
1201 Woodward Avenue, Suite 900
Detroit, MI 48226

Provider Services

The Molina Provider Contact Center handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. Molina Provider Contact Center representatives are available 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding state and federal holidays.

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

EDI Payer ID Number: 38334

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

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

Phone: (855) 322-4077
Availity portal: Welcome to Molina Healthcare, Inc - ePortal Services
Hearing Impaired (TTY/TDD): 711

Member Services

The Molina Member Contact Center handles all telephone inquiries regarding benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Contact Center representatives are available 8:00 a.m. to 5:00 p.m. Monday through Friday, local time, excluding State holidays.

Phone: (855) 322-4077

Hearing Impaired (TTY/TDD): 711

Claims

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

- Availity portal
- EDI Payer ID 38334

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

Claims Recovery Department

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

Claims Recovery correspondence mailing address:

Provider Recovery Disputes	Molina Healthcare of Michigan PO Box 2470 Spokane, WA 99210-2470
Refund Checks Lockbox	Molina Healthcare of Michigan 25874 Network Place Chicago, IL 60673-1258
Phone	(866) 642-8999
Fax	(888) 396-1167

Compliance and Fraud AlertLine

Suspect cases of fraud, waste, or abuse must reported to Molina. You may do so by contacting the Molina AlertLine or by submitting an electronic complaint using the website listed below. For additional information about fraud, waste, and abuse, please refer to the Compliance section of this Provider Manual.

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

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

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years, or sooner, depending on Molina's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network. For additional information about Molina's Credentialing program, including Policies and Procedures, please refer to the Credentialing and Recredentialing section of this Provider Manual.

24-hour Nurse Advice Line

This telephone-based Nurse Advice 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.

English Telephone: (888) 275-8750
Spanish Telephone: (866) 648-3537
Hearing Impaired (TTY/TDD): 711

Health Care Services

The Health Care Services (HCS) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. The HCS department also performs Care Management for Members who will benefit from Care Management 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.

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

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

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

- Submit requests directly to Molina via the Availity Essential portal

Health Management

Molina provides health management programs designed to assist members and their families to better understanding their chronic health condition(s) and adopt healthy lifestyle behaviors. The programs include:

- Molina My Health – Tobacco Cessation Program
- Molina My Health – Weight Management Program
- Molina My Health – Nutrition Consult Program

Phone: (833) 269-7830
Fax: (800) 642-3691

Mental Health

Molina manages covered services for mental health. For Member mental health needs, please contact us directly at (855) 322-4077. Molina has a Mental Health Crisis Line that Members may access 24 hours per day, 365 days per year by calling the Member Services telephone number on the back of their Molina ID card. For additional information, please refer to the Mental Health section of this Provider Manual.

Pharmacy

The prescription drug benefit is administered through CVS Caremark by Molina. A list of in-network pharmacies is available on the MolinaHealthcare.com website or by contacting Molina. For additional information, please refer to the **Pharmacy** section of this Provider Manual.

Telephone: (855) 322-4077 (8:00 a.m. - 8:00 p.m., local time, seven days a week)
Hearing Impaired (TTY/TDD): 711

Quality

Molina maintains a Quality department to work with Members and Providers in administering the Molina Quality Improvement (QI) Program. For additional information, please refer to the Quality section of this Provider Manual.

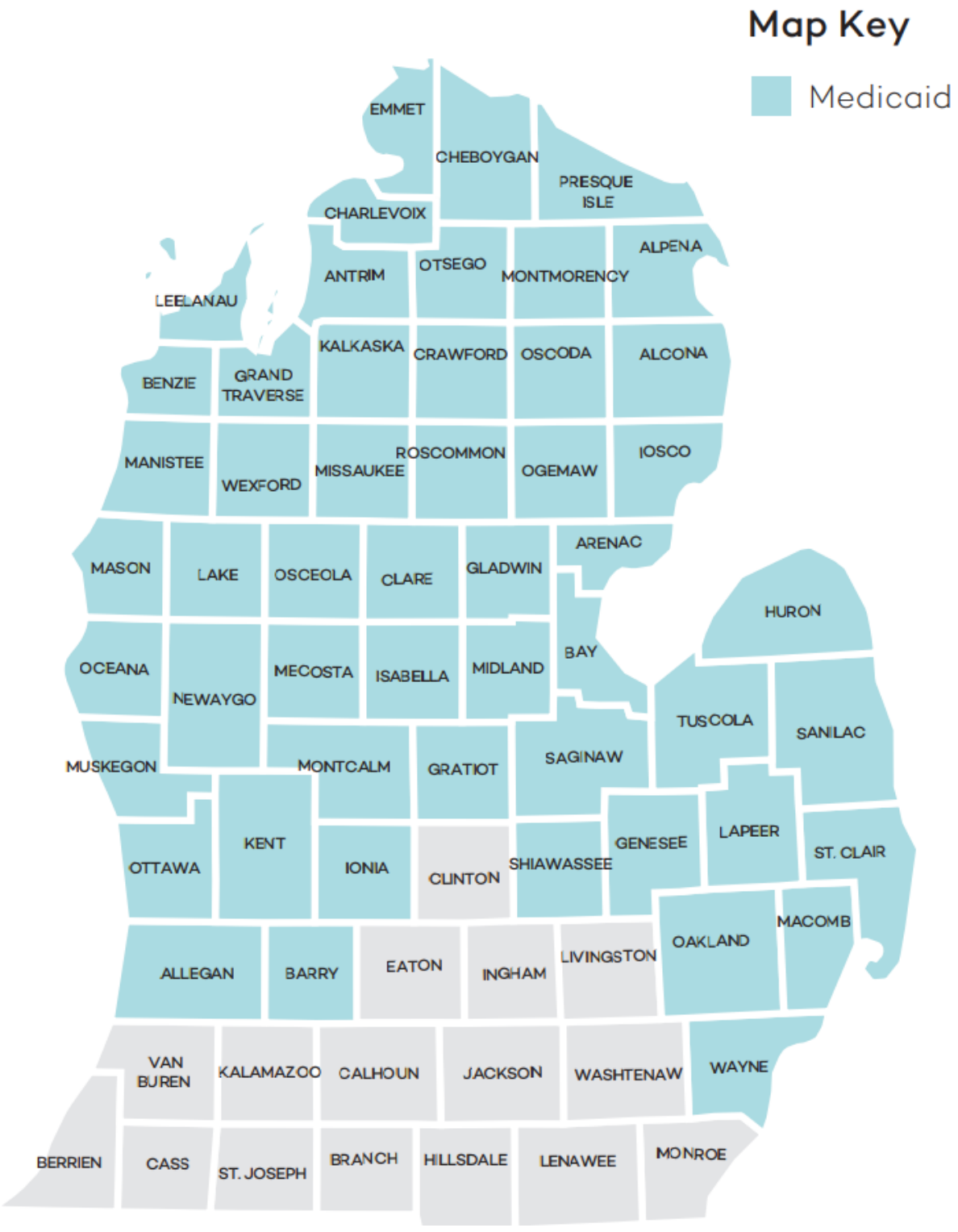
Telephone: (855) 322-4077
General Fax Number: (844) 861-1432
Notification of Pregnancy Form (NOP): Fax to (844) 861-1932
MIHP Enrollment and Discharge Notifications Forms: Fax to (844) 861-1932
Email: MolinaMIHP@molinahealthcare.com

Supplemental Services

Molina offers the following supplemental services benefits.

Service	Vendor Name & Address	Telephone
Dental	DentaQuest 11100 W. Liberty Drive Milwaukee, WI 53224 www.Dentaquest.com	(855) 609-5158
Vision	VSP 3333 Quality Drive, Rancho Cordova, CA95670	(800) 615-1883
Transportation	Access2Care/MTM	(888) 616-4842

Molina Healthcare of Michigan, Inc. Medicaid Service Area



ENROLLMENT, ELIGIBILITY AND DISENROLLMENT

Health Plans

Medicaid

Medicaid is a federal program created by Title XIX of the Social Security Act in 1965. The primary objective of the program is to provide essential medical and health services to those who would not otherwise have the financial resources to purchase them. Public and private agencies work together to administer the Medicaid Program.

Beneficiary eligibility for public assistance is determined by the Michigan Department of Health and Human Services (MDHHS). Michigan Enrolls is the enrollment broker for Michigan's Medicaid and MIChild programs and provides educational materials about the various health plans available in a member's county.

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

Michigan Enrolls also helps Medicaid beneficiaries pick the health plan of their choice. If members do not choose a health plan, Michigan Enrolls will assign the member to a health plan. Michigan Enrolls' phone number is (888) 367-6557.

Molina Healthcare is notified each month when Medicaid beneficiaries select our Plan. Members will have two cards, a Molina Healthcare identification card and a Michigan Medicaid identification card. The State sends a Medicaid identification card to each member. This card contains information on the member's Medicaid eligibility. Members should present both cards each time they receive a service. Following are some important eligibility points:

- Members who lose and then regain Medicaid eligibility within 60 days are automatically reassigned to Molina Healthcare and the previously assigned Primary Care Provider

- Newborns are automatically enrolled with the health plan the mother was enrolled in on the date of delivery. Parents may choose a different plan for the newborn after 30 days of the newborn's eligibility

Note: The newborn's and children in foster care eligibility in the Michigan Department of Health and Human Services CHAMPS system may not reflect HMO coverage for 30-60 days.

Inpatient at Time of Enrollment

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

Medicaid Programs

The State of Michigan, through Michigan Department of Health and Human Services (MDHHS) determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The Contractual Agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

MIChild

MIChild is a health insurance program for the uninsured children of Michigan's working families.

Eligibility is determined by the following criteria:

- Must be a U.S. citizen (some legal immigrants qualify)
- Must live in Michigan, even for a short period of time
- Must be under the age of 19
- Family must meet income requirements
- Children must not have other insurance coverage

MIChild applicants may submit applications online on MI Bridges at Newmibridges.michigan.gov Applicants may also submit applications to local health departments or calling the Michigan Health Care Helpline at (855) 789-5610. MIChild questions should be referred to (888) 988-6300.

Healthy Michigan Plan

The Healthy Michigan Plan (HMP) is a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 began April 1, 2014. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. Healthy Michigan Plan members may select Molina Healthcare for coverage. To enroll, residents must meet all of the following criteria:

- Between the ages of 19 and 64
- Not currently eligible for, or enrolled in other Medicaid programs
- Not eligible for, or enrolled in Medicare
- Earning up to 133 percent of the federal poverty level (about $17,000 for a single person or $35,000 for a family of four)
- Are not pregnant at the time of application

- Are residents of the State of Michigan

Physicians are not responsible for collecting copays from Healthy Michigan Plan members enrolled in a managed care plan. The health plans are responsible for collection of the member copay.

For more information on the Healthy Michigan Plan, please visit:
www.michigan.gov/healthymiplan

Dual Eligible

As of November 1, 2011, MDHHS allowed beneficiaries dually eligible for Medicaid and Medicare to enroll in Medicaid health plans. Molina Healthcare offers Medicare Advantage Dual Eligible Special Needs Plans in several counties.

Molina Healthcare will follow the Medicare eligibility guidelines.

Eligibility Listing for Medicaid Programs

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

- Molina Provider Services at (855) 322-4077
- Eligibility can also be verified through the state
    - Champs Eligibility Inquiry (800) 292-2550
    - Champs Email ProviderSupport@michigan.gov
    - Molina Provider Portal Provider.MolinaHealthcare.com
- Availity Essentials portal at provider.MolinaHealthcare.com

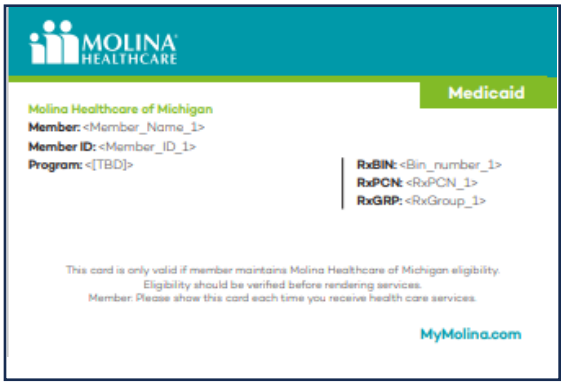
Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A member's eligibility may change monthly; a Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information. Services provided when a member is not enrolled with Molina Healthcare will not be covered.

Molina Healthcare Identification Cards

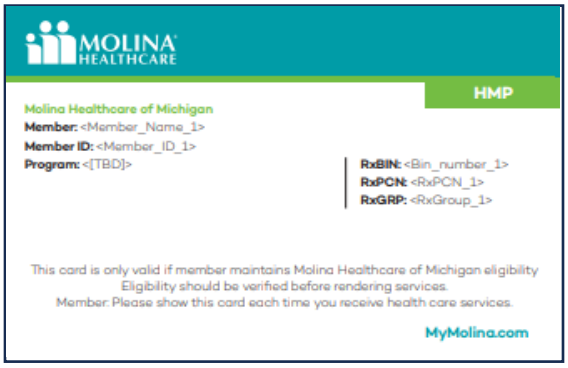
Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition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

Molina Healthcare identification cards identify which program (Medicaid and Healthy Michigan) the member is enrolled in. This information is located in the program field.

Medicaid ID Cards



Healthy Michigan Plan ID Cards



Eligibility

The following resources may be utilized to determine whether a patient is eligible to receive Molina Healthcare benefits for Medicaid or MIChild:

Please refer to the Medicaid Provider Manual Directory Appendix at www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf for information on eligibility verification through Medicaid.

Web Portal Eligibility Roster: www.MolinaHealthcare.com

Interactive Voice Response (IVR) System: (855) 322-4077

Molina Healthcare Member & Provider Contact Center: (855) 322-4077

Member Initiated Transfer Requests

Members desiring to change their Primary Care Physician (PCP) can call Member Services at (888) 898-7969 or complete and submit the Provider Request to Change PCP Form, located at www.MolinaHealthcare.com under Forms. PCP changes will be effective the date of the call or

the date the form is received. PCP name is no longer on ID card, so a new ID card will only be sent if requested by the Member.

Provider Initiated Transfer Requests (Discharge From Your Practice)

There may be times when a PCP requests a Member to be transferred to a different PCP.

Qualifying reasons for transfer/discharge identified below:

1. Verbal/Life Threatening:
    a. Physical Acts of Violence
    b. Verbal Threats of Violence/Verbal abuse
    c. Stalking (verbal or physical)
    d. Disruptive behavior
2. Fraud Misrepresentation:
    a. Alteration or Theft of Prescriptions
    b. Misrepresentation of Plan Membership
    c. Allowing another to fraudulently receive benefits
3. Non-Compliance:
    a. Failure to follow treatment plan/establish relationship
    b. Repeated use of the Emergency Room
    c. Drug Seeking Behavior
    d. Repeated use of non-plan physicians
    e. Those who impede medical care

Process for transfer/discharge identified below:

For discharge requests for disruptive behavior, PCP must document an explanation of the disruptive behavior and how it has impacted the PCP's ability to provide service to this Member or other patients in the PCP's practice.

For discharge requests for non-compliance, PCP must document a minimum of three (3) outreach attempts, with at least one by mail and one by phone within a 3-month time span.

If a PCP desires to transfer a Member for one the reasons above, the current PCP must inform the member in writing of the reason(s) for terminating the current physician/patient relationship and must also inform the member they have 30 days to choose another PCP. The written correspondence must be mailed to the member. A copy of the correspondence must be sent via email to MHMProviderServicesMailbox@MolinaHealthcare.com.

Providers should use the Provider Initiated Member Transfer/Discharge Request Form to notify Member Services of their desire to initiate a member transfer. The form is located in the Forms section of Molina Healthcare's website at www.MolinaHealthcare.com. A Member Services Representative can assist the member in reviewing the Provider Directory for available PCP choices.

When the PCP believes an immediate transfer is necessary, the PCP should contact Member Services at (888) 898-7969 for assistance.

Disenrollment

The Michigan Department of Health and Human Services (MDHHS) allows for disenrollment from Medicaid Health Plans via the following Voluntary/Involuntary Disenrollment protocol:

Voluntary Disenrollment

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

Reasons for Involuntary Disenrollment

Violent/Life-threatening: Situations that involve physical acts of violence; physical or verbal threats of violence made against providers, staff or the public; or where stalking situations exist.

Documentation for Involuntary Disenrollment

- Detailed documentation to support the disenrollment request
- Incident Report or summary of member actions is required from provider office
- Copy of PCP dismissal letter or correspondence to the member
- Copy of Police Report and reference number given by Police Department
- Copy of altered/forged prescription

Please see Beneficiary Monitoring Program (in Case Management section) for members that have committed fraud, misrepresentation and/or other actions inconsistent with plan membership.

Completed forms and documentation should be emailed to:

MHMProviderServicesMailbox@MolinaHealthcare.com

CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to assure that Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting Molina Provider Relations representatives.

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

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

Non-Discriminatory Credentialing and Recredentialing

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

Types of Practitioners Credentialed & Recredentialed

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

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Mental health care practitioners who are licensed, certified or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners

- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina Network

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

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

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

- **Application** – Practitioners must submit to Molina a complete credentialing application either from CAQH ProView or other State mandated practitioner

application. The attestation must be signed within 120 days. Application must include all required attachments.

- **License, Certification or Registration** – Practitioners must hold a current and valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the State where they are located and the State the Member is located.

- **Drug Enforcement Administration (DEA) Certificate** – Practitioners must hold a current, valid, unrestricted DEA or certificate. Practitioners must have a DEA in every State where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA, chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.

- **CDS Certificate** – Practitioners must hold a current, valid MI Controlled Dangerous Substances (CDS) certificate. Practitioners working from in network practice locations must meet CDS requirements in those states.

- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Molina Members.

- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.

- **Residency Training** – Practitioners must have satisfactorily completed residency training from an accredited program in the specialties in which they are practicing. Molina only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.

- **Fellowship Training** – Fellowship training is verified when a practitioner will be advertised in the directory in their fellowship specialty. Molina only recognizes fellowship programs accredited by ACGME, AOA, CFPC, and CODA.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed residency training from an accredited training program in the specialty in which they are practicing. Molina recognizes certification only from the following Boards:
    - American Board of Medical Specialties (ABMS)
    - American Osteopathic Association (AOA)
    - American Board of Foot and Ankle Surgery (ABFAS)
    - American Board of Podiatric Medicine (ABPM)
    - American Board of Oral and Maxillofacial Surgery
    - American Board of Addiction Medicine (ABAM)
    - College of Family Physicians of Canada (CFPC)
    - Royal College of Physicians and Surgeons of Canada (RCPSC)
    - Behavioral Analyst Certification Board (BACB)
    - National Commission on Certification of Physician Assistants (NCCPA)

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

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

- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[1]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities on Molina's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioners must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable

accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner.

- **Lack of Present Illegal Drug Use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions including any convictions, guilty pleas or adjudicated pretrial diversions for crimes against a person such as murder, rape, assault and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.

- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **NPI** – Practitioners must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).
- **Community Health Automated Medicaid Processing System** (**CHAMPS**) – All Practitioners must have active enrollment in the Michigan Medicaid Program and must meet the Michigan Department of Health and Human Services (MDHHS) requirements to be eligible to participate in the Molina network.

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

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

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

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

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available
- The Practitioner's response must be sent to:
  Molina Healthcare, Inc.
  Attention: Credentialing Director,
  22522 – 29th Drive SE, #L-210
  PO Box 4004
  Bothell, WA 98041

Upon receipt of notification from the Practitioner, Molina will document receipt of the information in the Practitioner's credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, corrections will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

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

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

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

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

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

Practitioner's Right to be Informed of Application Status

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

Professional Review Committee (PRC)

Molina designates a PRC to make recommendations regarding credentialing decisions using a peer review process. Molina works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to Molina members. The PRC reports to the Quality Improvement Committee (QIC.) Molina utilizes information such as, but not limited to, credentialing verifications, QOCs, and member complaints to determine continued participation in Molina's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, Practitioners should request a fair hearing as outlined below and in Molina's policy. Please contact Molina Provider Relations representatives for additional information about fair hearings.

Notification of Credentialing Decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the Molina Medical Director within two (2) weeks of the decision. Under no circumstance will notifications letters be sent to the Practitioners later than sixty (60) calendar days from the decision. Notification of recredentialing approvals is not required.

Recredentialing

Molina recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128. Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High Risk list –** Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** – Monitor for State Medicaid exclusions through each State's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Molina monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** – Molina enrolls all credentialed practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

Molina also monitors the following for all Practitioner types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Effective 07/01/2025, Molina will monitor the timely renewal of healthcare licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, Molina may take action up to and including payment suspension for dates of service on or after license expiration or termination from applicable Molina provider networks.

Provider Appeal Rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to Laws or regulations.

CLAIMS AND COMPENSATION

Payer ID	**38334**
Availity Essentials Portal	**provider.MolinaHealthcare.com**
Clean Claim Timely Filling	**365 calendar days after the discharge for inpatient services or the Date of Service for outpatient services as defined by regulation 42 CFR 447.45**

Electronic Claim Submission

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

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

Molina offers the following electronic Claims submission options:

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

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 (CMS-1450 [UB04]) Claims with attached files
- Correct/void Claims
- Add attachments to previously submitted Claims
- Check Claim status
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
- Create and manage Claim templates
- Create and submit a Claim appeal or Dispute with attached files
- Manage overpayment invoices (Inquire, Dispute and Resolve)

Clearinghouse

Molina uses The SSI Group as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

If you do not have a clearinghouse, Molina offers additional electronic claims submissions options as shown by logging on to the Availity Essentials portal.

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

When your Claims are filed via a Clearinghouse:

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

EDI Claims Submission Issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider relations representatives for additional support.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 365 calendar days after the discharge for inpatient services or the date of service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within 90 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim Submission

Participating Providers are required to submit Claims to Molina with appropriate documentation. Providers must follow the appropriate State and Centers for Medicare & Medicaid Services (CMS) Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA compliant American National Standards Institute (ANSI) X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 38334. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim submission instructions on the Member's Molina ID card.

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 report any changes in their NPI or subparts to Molina as soon as possible, not to exceed thirty (30) calendar days from the change. 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.

Required Elements

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

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

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

- 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, CPT or 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 information when different than billing
- 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), unit of measure and quantity for medical injectables
- E-signature
- Service facility location information
- Prior authorization number (if applicable)
- Any other state-required data

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.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized ASC X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 7. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

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

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

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice

(ERA). Without the original Claim number adjustment requests will generate a compliance error and the Claim will reject.

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

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address only. Claims received at other addresses will not be processed. Claims submitted to non-approved locations/pathways (e.g., Molina physical office locations) will be returned.

Molina Healthcare of Michigan, Inc.
PO Box 22668
Long Beach, CA 90801

When submitting paper Claims:

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

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Molina strongly encourages participating Providers to submit Corrected Claims electronically via EDI or the Availity Essentials portal.

All Corrected Claims:

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

- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500

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 CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 365 calendar days from the date of service.

Corrected Claims submission options:

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

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

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

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

Subrogation - Molina retains the right to recover benefits paid for a Member's health care services when a third-party is responsible for the Member's injury or illness to the extent permitted under State and Federal law and the Member's benefit plan. If third-party liability is suspected or known, please refer pertinent case information to Molina's vendor, **Katch IQ**, at **submitreferrals@katchiq.com**.

Hospital-Acquired Conditions (HAC) and (POA) Present on Admission program

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 by the use of

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 reduces 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 (CABG)
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 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

For additional information on the Medicare HAC/POA program, including billing requirements, please refer to the CMS website at cms.hhs.gov/HospitalAcqCond

Molina Coding Policies and Payment Policies

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

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Molina requires coding of both diagnoses and procedures for all Claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM
- For procedures:
  - Professional and outpatient Claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 HCPCS codes
  - 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 State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE).
    - In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCD)

    - In the absence of State guidance, Medicare Local Coverage Determinations (LCD)
  - CMS Physician Fee Schedule RVU indicators
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA)
- ICD-10 guidance published by the National Center for Health Statistics
- State-specific Claims reimbursement guidance
- Other coding guidelines published by industry-recognized resources
- Payment policies based on professional associations or other industry-recognized guidance for specific services; such payment policies may be more stringent than State and Federal guidelines
- Molina policies based on the appropriateness of health care and medical necessity
- Payment policies published by Molina

Telehealth Claims and Billing

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

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type in accordance with applicable billing guidelines MDHHS Provider Manual. For additional information please refer to Molina's Telemedicine, Telehealth Services and Virtual visit policy at Molina Healthcare Billing and Reimbursement Policies.

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 the 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 (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

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

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service 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 (1) 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 ICD-10-CM and 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 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

POS codes are two (2)-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 code should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care,

also referred to as a “frequency” code. For a complete list of codes, reference the National Uniform Billing Committee’s (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

National Drug Code (NDC)

The NDC must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04), or its electronic equivalent.

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

Coding Sources

Definitions

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

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

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

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

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

Claim Auditing

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

The 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, the Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Molina utilizes ICD-10-CM and ICD-10-PCS billing rules and will deny Claims that do not meet Molina's ICD-10 Claim Submission Guidelines.

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

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

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina or contracted

medical group/IPA have agreed in writing to an alternate schedule, Molina will process the Claim for service according to federal and state Clean Claim regulations.

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

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and 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. Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting our Provider Contact Center.

Overpayments and Incorrect Payments Refund Requests

Molina requires network Providers to report to Molina when they have received an overpayment and to return the overpayment to Molina within 60 calendar days after the date on which the overpayment was identified and notify Molina in writing of the reason for the overpayment.

If, because of retroactive review of Claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment by adjusting the Claim.

A copy of the overpayment request letter and details are available in the Availity Essentials 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.

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

Overpayments related to TPL/COB will be adjusted in Molina's claims processing system and providers will not receive an overpayment notification letter. However, the claim adjustment 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.

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.

Claim Disputes/Reconsiderations/Appeals

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

Balance Billing

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 Member for covered services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

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

Encounter Data

Each Provider, capitated Provider, or organization delegated for Claims processing is required to submit Encounter data to Molina for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and Healthcare Effectiveness Data and Information Set (HEDIS®) reporting.

Encounter data must be submitted at least monthly following the Clean Claims regulations in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any Encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within fifteen (15) days from the rejection/denial.

Molina has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission
- Second, Molina will provide a 277CA response file for each transaction

APPEALS AND GRIEVANCES

Provider Appeals

The Molina Appeals team coordinates clinical review for Provider Appeals with Molina Medical Directors.

All Providers have the right to appeal any denial decision made by Molina. Any denied claim for a service that requires authorization is considered a post-service appeal. Our appeal process is objective, thorough, fair, and timely. A Molina Medical Director can also determine that a same specialty physician review may be needed. Providers must submit all appeals via one of the methods listed below (listed in order of preference):

1. Online Provider Portal: provider.molinahealthcare.com/Provider/Login
2. Fax: (248) 925-1768
   Molina Healthcare of Michigan
   Attn: Provider Appeals
3. Mail: (Molina accepts CDs)
   Molina Healthcare of Michigan
   Attn: Provider Appeals
   PO Box 182273
   Chattanooga, TN 37422

Retrospective Authorization*

Retrospective Authorization is considered a request for initial authorization after a service has been rendered and/or failure to authorize services according to the required timeframes.

Retrospective authorization is not a Molina process, except in the event of extenuating circumstances. An extenuating circumstance is defined as:

1. Provider did not know nor reasonably could have known that the patient was a Molina Member at the time the service was rendered

Examples:

- Member does not have insurance cards on them at time they arrived
- Eligibility IVR system is offline
- Woman presents in labor and has other insurance, Molina is secondary insurer and card not presented at time of admission
- Member has pending Medicaid at the time of service

2. Provider couldn't have known that patient needed a service that required authorization prior to the service being rendered

Examples:

- Elective outpatient surgery authorization is obtained for a specific service; however, the Member presents with an additional and/or different service that requires an authorization.
- Surgery for shoulder repair which turns out to be more extensive than planned
- Member originally requires an Elective surgery that does not require authorization; however, when the Member presents an additional and/or different Elective surgery service is needed that requires authorization
- Planned diagnostic hysteroscopy which results in the removal of a leiomyoma (fibroids)
- Member originally requires an Outpatient service that does not require authorization; however, when the member presents an additional and/or different Outpatient service is needed that requires authorization
- Member has had a TIA and is need of a Speech Therapy evaluation for swallowing; evaluation indicates that 12 visits are needed. (Evaluation + 6 visits do not require an authorization. The remaining visits would require an authorization.)
- Member is evaluated for a manual wheelchair which does not require an authorization; the evaluation showed that a power wheelchair was recommended which does require an authorization

3. Molina Error

   Documentation to demonstrate extenuating circumstances must be submitted at the time of the request. All requests for retrospective authorization with an extenuating circumstance must be received within ten (10) calendar days of becoming aware of the extenuating circumstance. Determinations, in this circumstance, will be based on medical necessity guidelines and UM policies and criteria.

   You may request a Retrospective Authorization with extenuating circumstance.** Molina offers the following electronic Prior Authorizations/Service Requests submission option:

   - Submit requests directly to Molina via the Availity Essentials portal

   **Please note if there is a denied claim on file the Provider Appeal process will need to be followed. Refer to the Provider Appeals and Grievances Section.

Appeals and Grievances

Pre-Service Appeal*

Pre-service is considered an appeal of any adverse determination prior to rendering the requested service or procedure. If a claim has been denied for an authorization, please refer to the Post-Service Appeal process.

In the event an authorization has been denied, Providers may submit an appeal on behalf of the Member (with written approval to act as a designated representative) within 60 calendar days of the denial, prior to the service being completed. The Provider may serve as designated representative for the Member and act on their behalf (hereafter referred to as "representative"). The representative can be a friend, a family member, health care Provider, or an attorney. An Authorized Representative Form can be found on Molina-Member website at http://www.molinahealthcare.com/providers/mi/medicaid/forms/Pages/fuf.aspx

Continued Stay Review

In the event of an inpatient admission authorization denial, Providers may submit additional medical records and request a Continued Stay Review by contacting (855) 322-4077.

Note: Providers may review the UM criteria with Molina or they may request a copy of the criteria used to make the medical necessity determination by fax or email.

A Molina Medical Director is available for peer-to-peer consultation to discuss the denial decision with any treating Practitioner regarding medical necessity.

Listed below are the timeframe requirements by line of business and service type:

	Medicaid
Preservice	Requesting provider has five (5) business days from receipt of the denial notification to initiate a peer-to-peer if no formal appeal has been filed. If a formal appeal is filed, the appeal process must be followed.
Inpatient	Peer to Peer can be initiated five (5) business days from denial notification, regardless of inpatient or discharge status.
Pharmacy	Requesting Provider has five business days from receipt of the denial notification to schedule a P2P. Call (888) 898-7969.
Out of timeframe for the Peer-to-Peer	Requesting Provider is instructed to file an appeal on behalf of the Member or submit a claim and follow the Provider appeal/reconsideration/dispute process.

	Medicaid
After discussing the case with the requesting provider, Molina MD requests that additional information be submitted to Molina, following the Peer-to-Peer:	Additional information must be received by the requesting Provider within one business day following the peer-to-peer.
	If the additional information is received AFTER the established turnaround times, thirteen days for non-urgent and two days for urgent preservice, Molina will notify the Provider stating that: The initial decision will be upheld and instruct the Provider to file an appeal on behalf of the Member or submit a claim and file a claims dispute/reconsideration
	Prior to discharge, see Inpatient row of Preservice section immediately above.

Medicaid – Peer-to-Peer Review Process Exceptions
A third-party vendor, Member or anyone other than the Provider directing the care of the Member. A request was administratively denied (e.g. non-covered benefit or exhaustion of benefits). An appeal has been submitted and filed. A peer-to-peer, for the same request, has already occurred. Post-Service requests: services have been rendered (provided). Concurrent requests (concurrent review): The Member has been discharged. If the peer-to-peer is requested after five business days from receipt of the denial notification.

Post-Service Appeal*

*Post-service is considered an appeal of any adverse determination after rendering a service or procedure. There are two types of post-service Provider appeals:

1. Administrative Decisions
2. Medical Necessity Review.

Administrative Denials

Molina has a one level appeal process for the Practitioner/Provider appeal of post-service administrative denials. An example of an administrative denial is failure to authorize services according to required time frames. Retrospective authorization is not a Molina process, except in the event of extenuating circumstances. If a clean claim has not been submitted and an extenuating circumstance exists, these requests should follow the Health Care Services section of this Provider Manual.

Level 1

A. The appeal must include NEW supporting evidence and/or documentation justifying the service, care or treatment being appealed and reason for notification outside of Molina notification timeframes. Portions of the medical record may be submitted.
    a) Reason Authorization was not obtained
    b) History and Physical
    c) Consultations
    d) Physician Progress Notes

e) Laboratory Results
f) Radiology Results
g) Emergency Department Summary
h) Physician Discharge Summary
i) Leaving Against Medical Advice information

B. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
C. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
D. A decision will be rendered, and notification provided within 30 calendar days of the receipt of a post-service appeal.

Medical Necessity Denials

Molina has a two-level appeal process for the Practitioner appeal of post-service medical necessity denials. An example of medical necessity denials are inpatient admissions which did not meet medical necessity criteria guidelines.

Level 1

A. A Practitioner/Provider must submit a written appeal within 90 calendar days of the claim denial notification.
B. The appeal must include NEW supporting evidence and/or documentation justifying the service, care or treatment being appealed. The appeal must also include information to reference the specific location of the supporting evidence and/or documentation. Portions of the medical record may be submitted:
    a) History and Physical
    b) Consultations
    c) Physician Progress Notes
    d) Laboratory Results
    e) Radiology Results
    f) Emergency Department Summary
    g) Physician Discharge Summary
    h) Leaving Against Medical Advice information
C. If medical records or supporting documentation is not submitted, appeal will be dismissed for lack of documentation.
D. Upon receipt of the appeal, the Medical Director, or other qualified physician, will review all documentation submitted and fully investigate all aspects of the clinical care provided without deference to the original determination.
E. The Medical Director, or other qualified physician, will/may consult with a physician of the same or similar specialty as the case in review.
F. A decision will be rendered and written notification provided within 30 calendar days of the receipt of a post-service appeal.

Level 2

A. If you disagree with the Level 1 appeal decision, a Practitioner must submit a second level written appeal within 90 calendar days of the date of the Level 1 denial notice. The request must clearly state it is for a Level 2 review.
B. The written Level 2 appeal request must include additional supporting documentation not previously submitted with the Level 1 Appeal, or it will be dismissed as same as Level 1. Some examples of additional supporting documentation include:
    a) A rebuttal to Molina's Level 1 appeal denial rationale
    b) How the Member met evidence-based care guidelines from MCG.
    c) Clinical documentation (i.e. chart notes)
C. The appeal will/may be reviewed by a Medical Director or by a consultant of same or similar specialty.
D. The Medical Director will render a decision and written notification will be provided within 30 calendar days of the receipt of a post-service appeal.

Timely Filing, Code Edit, COB, and Over/Under Payment Appeal/Disputes

Molina has a Claim Dispute Request Form that must be completed for Timely Filing, Code Edit, COB, and Payment Disputes. Failure to complete the Claim Dispute Request form will result in a delay in processing the request. The Claim Dispute Request Form can be found on Molina's website under Health Care Professionals: Frequently Used Forms

Timely Filing Appeal/Disputes

Timely Filing disputes must be submitted on a completed Claim Dispute Request Form with supporting documentation showing extenuating circumstances for not submitting the claim within standard timely filing limit. If claim was billed to another payer, please include the submission date and denial date by the other payer. For retro enrollment claims, include the date the members eligibility was updated to Molina.

Code Edit Appeal/Disputes (Correct Coding Initiative Edits)

CCI Edit disputes must be submitted on a completed Claim Dispute Request Form with supporting documentation and medical notes/reports within 90 calendar days of the clean claim remit date. In the event of a billing error, submit a corrected claim, not an appeal. Do not use a Claim Dispute Request Form to submit a corrected claim.

Coordination of Benefits (COB) Disputes

A COB dispute exists when Molina requires a claim to be resubmitted with the primary payers Evidence of Payment attached. If the primary coverage is not applicable on the date of service, the COB dispute must be submitted with supporting documentation within 180 days of the primary payer's remit date. Complete a Claims Dispute Request Form.

Rapid Dispute Resolution Process (RDRP)

Molina supports the Michigan Department of Health and Human Services (MDHHS) Rapid Dispute Resolution Process (RDRP) for non-contracted hospitals that participate in the MDHHS Hospital Access Agreement. Provider disputes submitted through the RDRP process will be reviewed and resolved in accordance with applicable MDHHS requirements. After all the appeal processes have been exhausted, request must be initiated within one year of the date of service or an extenuating circumstance; otherwise, it shall be deemed waived.

RDRP requests will be processed in a timely and efficient manner and in compliance with all applicable state and federal laws and regulations.

Non-contracted hospitals that have signed the MDHHS Hospital Access Agreement may submit written requests for RDRP to:

Molina Healthcare of Michigan
Attn: Appeals and Grievances (RDRP or Arbitration)
PO Box 182273
Chattanooga, TN 37422

Binding Arbitration and Alternative Dispute Resolution

For contracted and non-contracted providers that are not covered under the MDHHS Hospital Access Agreement, such providers must first fully exhaust all levels of Molina's appeal process before pursuing either binding arbitration as further described in the applicable contract between Molina and the contracted provider, or any other legal remedy available to non-contracted providers.

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

For providers contracted by Molina, arbitration must be initiated within one (1) year of the date of service.

Contracted and non-contracted providers that are not covered under the MDHHS Hospital Access Agreement may request additional guidance regarding available dispute resolution options. After first fully exhausting Molina's appeal process, contracted providers may be eligible to pursue binding arbitration as specified in the governing contract, and for non-contracted providers, such providers may initiate any other dispute as permitted and available under applicable law.

Molina will process requests for arbitration or other requests to initiate a formal legally recognized claim by submitting such requests to:

Molina Healthcare of Michigan
Attn: Appeals and Grievances
PO Box 182273
Chattanooga, TN 37422

Provider Rights

Rights to copies of documents: A Practitioner may request Molina to furnish all documents relevant to the Member's appeal as well as copies of the actual benefit provision, guideline, protocol, or criteria on which the appeal decision was based.

Right to know practitioners participating in the appeal: A Practitioner may request Molina to furnish the names, titles, and qualifications of any medical experts whose advice was obtained on behalf of Molina in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision.

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.

Member appeals processes

Molina Enrollees or the personal representatives of Enrollees have the right to file a grievance and submit an appeal through a formal process. All appeals must first be submitted to Molina within 60 days of the Adverse Benefit Determination. Appeals not resolved wholly in the Enrollee's favor can be appealed to the Michigan Office of Administrative Hearings (MOAHR).

This section addresses the identification, review, and resolution of Enrollee's appeal.

Appeals may be submitted by Enrollees or an authorized representative, such as a family member or the Provider, on behalf of the Enrollee in response to an Adverse Benefit Determination. If the appeal is submitted by someone other than the Enrollee, a signed Molina Healthcare of Michigan Authorized Representative Designation form must be included with submission. If Molina's decision is to deny a service in whole or part, Enrollees and Providers are notified of the following at the time of denial:

- Their right to appeal the decision.
- The process by which the appeal process is initiated.
- The Molina Member Services phone number, where more information regarding the appeals process can be obtained.

Enrollee types of appeals

An Enrollee may request an expedited appeal or standard appeal. Appeals may be filed orally or in writing. Appeals are filed to request that Molina change an adverse determination for care or services submitted by the Enrollee or their authorized representative. Appeals may be requested within 60 days of the Adverse Benefit Determination notice.

An expedited appeal request is submitted to the plan for review of an Adverse Benefit Determination if the standard appeal time frame indicates 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:

- Placing the individual in (or, with respect to a pregnant woman, the health of the woman or her unborn child) serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Enrollee authorized representative

An Enrollee may appoint an authorized representative to act on his/her behalf. The representative may be a guardian, caretaker, relative, health care Provider, or an attorney. Any standard appeals requested on behalf of the Enrollee must have the written authorization from

the Enrollee. If an authorized representative is filing an appeal on behalf of the Enrollee, an Authorized Representative Designation form must be completed, signed by the Enrollee, and submitted with the appeal request. Molina can provide the form as needed.

Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee, or supports an appeal filed by an Enrollee.

Standard appeals may be received orally or in writing within 60 calendar days following the date of the notice of action. An oral appeal request may be filed by calling Molina's Customer Service department. Standard appeal requests submitted in writing should be sent to Molina via this fax number or mailing address:

Fax: (248) 925-1799

Molina Healthcare of Michigan, Inc.
Attention: Member Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422

All appeal requests must include the Enrollee's name, address, Member number, reasons for appealing, and documentation or evidence such as medical records, physician letters, or other important information that explains the reason the service or item is needed. An Authorized Representative Form should be attached to the request when appropriate on behalf of an Enrollee. An appeal request submitted after the 60-day time frame must provide good cause (such as the Enrollee being seriously ill preventing the ability to file the appeal) for Molina to consider the late request.

Upon receipt of an appeal, Molina will notify the party filing the appeal of all information that is required to evaluate the appeal. A written acknowledgement will be sent to the Enrollee within five (5) business days of receipt.

Molina will render a decision on the appeal within 30 calendar days after receipt of the written appeal request. Molina will orally notify the following of its decision: the party filing the appeal, the Enrollee or authorized representative of the Enrollee, PCP, and any health care Provider who recommended the service involved in the appeal. Oral notification will be followed up by a written notice of determination.

No one reviewing an appeal may have had any involvement in the initial determination that is the subject of the appeal.

Written notifications of the appeal decision will contain reasons for the determination, including the medical or clinical criteria used to make the determination.

If the Enrollee is dissatisfied with the outcome of an appeal, the Enrollee or authorized representative may request an external independent review.

Members who are not satisfied with Molina's resolution of any appeal may request a state hearing with the Michigan Office of Administrative Hearings (MOAHR)

Michigan Office of Administrative Hearings and Rules
611 W. Ottawa St.
Ottawa Building, 2nd Floor
P.O. Box 30695
Lansing, MI 48909
Fax: (517) 335-6696
Phone: (800) 648-3397
Online: MOAHR-BSD-Support@michigan.gov

Enrollee expedited internal appeals process and timeline

Expedited appeals may be received orally or in writing within 10 calendar days from the date of the notice of action. Any requests submitted in writing should be sent to the address or fax number noted above under the Standard Appeal Process section. Expedited appeal requests on behalf of the Enrollee do not require signed written consent of the Enrollee. A request to expedite an appeal will be considered in situations where applying the standard appeal time frame could seriously jeopardize the Enrollee's life, health, or ability to regain maximum function. An expedited review is not possible when services have already been provided to the Enrollee.

Upon receipt of appeal, Molina will notify the party filing the appeal as soon as possible, and within no more than 24 hours after receipt, of all information that is required to evaluate the appeal.

Molina will render a decision within 72 hours after receiving expedited appeal request. If additional information required to make the final appeal determination is not received, a determination will be made with the current information available.

If it is determined the expedited appeal request does not meet expedited criteria, the request will be processed under the standard appeal time frame of 30 calendar days from the date the request was received.

Molina will orally notify the party filing the appeal, the Enrollee (or designated representative), the Enrollee's PCP, the requesting Provider, and any health care Provider who recommended the service involved in the appeal, of its decision. Oral notification will be followed up by a written notice of determination within two (2) calendar days following the oral notification.

Enrollee external independent review

An external independent review may be requested by an Enrollee or authorized representative either orally or in writing.

Requests for external independent review must be submitted within 127 days of receipt of written notification of a denied appeal. Written requests must be accompanied by any information or documentation to support the Enrollee's request for Covered Service or claim for a Covered Service.

An enrollee can submit their request for an external independent review to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Phone: (877) 999-6442
Fax: (517) 284-8838
Online: Difs.state.mi.us/Complaints/ExternalReview.aspx

Molina will do the following for external independent reviews:

> Molina will forward all medical records and supporting documentation, with a description of the applicable issues, and a statement of Molina's decision along with the criteria used and medical and clinical reasons for the decision to the external independent reviewer. The external independent reviewer will evaluate and analyze the case and render a decision for all standard requests. The decision by the independent review is final. If the reviewer determines the health care service to be medically appropriate, Molina will pay for the service.

Enrollee continuation of benefits

Enrollees may file for a continuation of benefits on or before the latter of ten (10) days from the Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination. Molina will continue the Enrollee's benefits during the appeal process. A Provider serving as the Enrollee's authorized representative for the appeal process cannot file for continuation of benefits.

Enrollee grievance process

Molina has an organized grievance process to ensure thorough, appropriate, and timely resolution to an Enrollee's grievances. A grievance is an expression of dissatisfaction that may include, but is not limited to:

- Requests for disenrollment.
- Difficulty finding a Provider.
- Unhappy with the Prior Authorization process.
- Services provided by Molina staff or Molina Providers.

If an Enrollee is unhappy with Molina or its Providers, they may file a grievance by contacting Member Services at: (888) 898-7969.

An Enrollee can also file a grievance in writing via mail or fax at:

Molina Healthcare of Michigan, Inc.
Member Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422
Fax: (855) 502-5128

Enrollees are notified of their grievance rights through various general communications including, but not limited to, the Member Handbook, Evidence of Coverage and Disclosure, Member newsletters, and Molina's website.

Enrollees may identify an individual, including an attorney or Provider, to serve as a personal representative to act on their behalf at any stage during the grievance. If under applicable law, a person has authority to act on behalf of an Enrollee in making decisions related to health care or is a legal representative of the Enrollee, Molina will treat such person as a personal representative. Providers are permitted to submit a grievance on behalf of the Enrollee; however, signed consent from the Enrollee is required. Molina will ensure that no punitive action is taken against a Provider who acts as an authorized representative on behalf of the Enrollee or supports a grievance filed by an Enrollee.

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

Any grievance or appeal concerning Potential Quality of Clinical Care is referred to the Quality Improvement (QI) department for documentation and further investigation when appropriate. Additionally, any identified issue related to the privacy and confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

Enrollee grievance timelines

An Enrollee may file a grievance at any time. Grievances may be submitted by phone or in writing. When submitted by phone to Member Services, the call will serve as acknowledgment of the grievance. When submitted in writing, a written acknowledgement

of the grievance will be sent to the Enrollee within 5 calendar days from receipt. A determination will be made as expeditiously as possible but no later than 90 calendar days from receipt of the grievance. Molina will provide the Enrollee (or designated representative) a notification of outcome.

Reporting

Grievance and appeal trends are reported to the Quality Improvement and Health Equity Transformation 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 and Health Equity Transformation 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 (ten) years. In addition to the information documented electronically via the Appeals and Grievances log or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. The Provider shall maintain records for a period not less than 10 (ten) years from the termination of the Model Contract and retain further if the records are under review or audit until the review or audit is complete. The Provider shall request and obtain Molina's prior approval for the disposition of records if agreement is continuous.

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 to ensure medications used to treat a variety of conditions and diseases are offered. 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 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. Molina's network includes, retail, mail, long term care and specialty pharmacies. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaHealthcare.com or calling Molina at (855) 322-4077.

Drug Formulary

Molina keeps a list of drugs, devices, and supplies that are covered under the plan's pharmacy benefit. The list shows all the prescription (and over-the-counter products where applicable) that Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. The pharmacy program does not cover all medications. For a complete list of covered medications please visit: www.molinahealthcare.com/providers/mi/medicaid/drug/formulary.aspx

Information on procedures to obtain these medications is described within this document and also available on the Molina website at: www.molinahealthcare.com/providers/mi/medicaid/drug/formulary.aspx

Formulary Medications

Formulary medications with PA may require the use of first-line medications before they are approved. Information on procedures to obtain these medications is described within this document and is also available on the Molina website at: www.molinahealthcare.com/providers/mi/medicaid/drug/formulary.aspx

Quantity Limitations

In some cases, Members may only be able to receive certain quantities of medication. Information on specific limits can be found in the formulary document. Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) guidance for the appropriate use of pharmaceuticals.

Step Therapy

Plan restrictions for certain Formulary drugs may require that other drugs be tried first. The Formulary designates drugs that may process under the pharmacy benefit without prior authorization if the Member's pharmacy fill history with Molina shows other drugs have been tried for certain lengths of time. If the Member has trialed certain drugs prior to joining Molina, documentation in the clinical record can serve to satisfy requirements when submitted to Molina for review. Drug samples from Providers or manufacturers are not considered as meeting step therapy requirements or as justification for exception requests.

Non-formulary Medications

Nonformulary medications may be considered for exception when formulary medications are not appropriate for a particular Member or have proven ineffective. Requests for formulary exceptions should be submitted using a PA form which is available on the Molina website at MolinaHealthcare.com. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of a manufacturer's samples of Non-Formulary or "Prior Authorization Required" medications does not override Formulary requirements.

Generic Substitution

Generic drugs should be dispensed when preferred. If the use of a particular non-preferred brand name drug becomes medically necessary as determined by the Provider, PA must be obtained through the standard PA process.

New-to-Market Drugs

Newly approved drug products will not normally be placed on the formulary during their first six (6) months on the market. During this period, access to these medications will be considered through the PA process.

Medications Not Covered

There are some medications that are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes may not be part of the benefit. For a complete list of drugs excluded from the plan benefit please refer to the formulary document on Molina's at Drug Formulary (molinahealthcare.com)

These exclusions are determined by the Michigan Department of Health and Human Services.

Submitting a prior authorization request

Molina's vendor, CVS Caremark will only process completed PA request forms; the following information MUST be included for the request form to be considered complete.

- Member first name, last name, date of birth and identification number
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use
- Diagnosis

Electronic prior authorization (ePA): SureScripts® and CoverMyMeds

CVS Caremark's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, CVS Caremark will either respond via the electronic prior authorization (ePA) portal, fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

CVS Caremark utilizes electronic PA prior authorization portal submissions through the SureScripts® and CoverMyMeds® platforms that are integrated into physician office electronic health record (EHR) systems. The Electronic prior authorization (ePA) portal automates the PA prior authorization process, making it a quick and simple way to complete PA prior authorization requests. The ePA portal process is HIPAA compliant and can enables faster coverage determinations. For select drugs and plans, CoverMyMeds® may issue immediate approval of your request and update your patient's PA prior authorization record to allow immediate claim adjudication.

Fax a completed Medication PA Request form to CVS Caremark at (888) 373-3059. A blank Medication PA Request Form is available on Molina's website at https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/mi/MolinaUMPharmacyDEPARequestForm_R.ashx or by calling CVS Caremark at (800) 552-8159.

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.

Specialty Pharmaceuticals, Injectable and Infusion 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. Some of these same medications may be covered through the medical benefit using

Healthcare Common Procedure Coding System (HCPCS) via paper or electronic medical Claim submission.

During the utilization management review process, Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any Federal or State regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing. Molina may conduct a peer-to-peer discussion or other outreach to evaluate the level of care that is medically necessary. If an alternate site of care is suitable, Molina may offer the ordering Provider help in identifying an in-network infusion center, physician office or home infusion service and will help the Member coordinate and transition through case management.

If it is determined to be a Pharmacy benefit, 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.

Newly FDA-approved medications 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. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

Molina clinical services complete utilization management for certain Healthcare Administered Drugs. Any drugs on the PA list that use a temporary C code or other temporary HCPCS code that is not unique to a specific drug, which are later assigned a new HCPCS code, will still require PA for such drug even after it has been assigned a new HCPCS code, until otherwise noted in the PA list.

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority for all of us in health care. Molina requires Providers to adhere to Molina's drug formularies and prescription policies designed to prevent abuse or misuse of high-risk chronic pain medication. Providers are expected to offer additional education and support to Members regarding Opioid and pain safety as needed.

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at MolinaHealthcare.com under the Health Resource tab.

Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

HEALTH CARE SERVICES

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model of care based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, member-centric care environment for at-risk members supports better health outcomes. Molina provides CM services to members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Molina UM program include pre-service authorization review, inpatient authorization management that includes pre-admission, admission and concurrent medical necessity review, and restrictions on the use of out-of-network or non-participating Providers.

Utilization Management (UM)

Molina ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. Molina's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence a member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care
- Evaluating the medical necessity and efficiency of health care services across the continuum of care
- Defining review criteria, information sources, and processes that are used to review and approve the provision of items and services
- 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
- Ensuring 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 qualified health care professionals perform all components of the UM process
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decisions

Key Functions of the UM Program

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

- **Eligibility and Oversight**
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to member's medical necessity need(s) & benefit plan
  - Verifying of current physician/hospital contract status
- **Resource Management**
  - Prior Authorization and referral management
  - Admission and Inpatient Review
  - Referrals for Discharge Planning and Care Transitions
  - Staff education on consistent application of UM functions
- **Quality Management**
  - Evaluate satisfaction of the UM program using member and provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - 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.

UM Decisions

An organizational determination is any decision made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination)
- Determination to delay, modify, or deny authorization (adverse determination)

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 reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal and State regulatory requirements and NCQA standards.

Requests for authorization not meeting medical necessity 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 authorization of services to a member.

Providers can contact Molina's Healthcare Services department at (855) 322-4077 or fax (800) 594-7404 to obtain Molina's UM Criteria.

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.

Medical Necessity

Medically Necessary or Medical Necessity means health care services provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate to prevent or for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Molina has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for 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 for 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 for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Molina has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for Medicaid, Medicare and Marketplace lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity 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 your authorization request, and the status of the authorization will be available immediately upon completion of your 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. To see the full list of imaging codes that require PA, refer to the PA code Look-Up Tool at MolinaHealthcare.com.

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. To determine medical necessity, in conjunction with independent professional medical judgment, Molina uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, State guidelines, clinical policies, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Molina review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or Participating Provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at Molina (medical director, pharmacy director, or appropriately licensed health care professional).

Molina's Provider training includes information on the UM processes and Authorization requirements.

Clinical Information

Molina requires copies of clinical information 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 case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allow such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Provider Agreement with Molina. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at MolinaHealthcare.com. Providers are encouraged to use the Prior Authorization Lookup Tool to verify if a service requires prior authorization.

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).

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

Molina will make organizational determination as promptly as the member's health requires and no later than contractual and regulatory requirements. Expedited timeframes are followed when the provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a member's life or health.

Providers who request prior authorization for services and/or procedures may request to review the criteria used to make the final decision. A Molina Medical Director is available to discuss medical necessity decisions with the requesting provider at (855) 322-4077 during business hours.

Upon approval, the requester will receive an authorization number. The number may be provided by telephone or via the Availity Essentials portal. If a request is denied, the requester and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Providers may receive notifications or denials by phone or via the Availity Essentials portal.

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion.

A "peer" is considered the member's or provider's clinical representative (licensed medical professional). Contracted external parties, administrators, or facility UM staff can request that a peer-to-peer telephone communication be arranged and performed but the discussion can only be performed by a peer.

A Molina Medical Director is available for peer-to-peer consultation to discuss the denial decision with any treating practitioner regarding medical necessity.

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

- Member name and Molina Member ID number
- Authorization ID number
- Requesting Provider Name and contact number and best times to call

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

Listed below are the timeframe requirements by line of business and service type:

Timeframe Requirements for Peer-to-Peer Review Note: One Peer-to-Peer discussion is allowed for each adverse determination.		
	Medicaid/Marketplace	**Medicare**
Pre-service	Pre-Service: Requesting provider has five (5) business days from receipt of the denial notification to initiate a peer-to-peer if no formal appeal has been filed. If a formal appeal is filed, the appeal process must be followed	Requesting provider can request a Peer-to-Peer review any time **PRIOR** to an adverse determination being made. ***Scheduling Exceptions*:** None
Inpatient	Inpatient: Peer to Peer can be initiated five (5) business days from denial notification, regardless of inpatient or discharge status.	An adverse determination can be changed during a Peer-to-Peer conversation to an approval at any time while the member is still inpatient.
SNF/IPR/LTAC	SNF/IPR/LTAC: For the initial authorization request, a peer-to-peer regarding an adverse determination can occur at any time while the member is still inpatient. For concurrent requests, the peer-to-peer regarding an adverse determination can occur while the member is still in the facility.	An adverse determination can be changed during a Peer-to-Peer conversation to an approval at any time while the member is still inpatient.
Pharmacy	Requesting provider has five (10) business days from receipt of the denial notification to schedule a Peer-to-Peer discussion. Call 888-898-7969.	N/A
Out of timeframe for the Peer to Peer	Pre-service: The requesting provider is instructed to file an appeal on behalf of the member. Post-Service: The requesting provider is instructed to submit a claim and follow the provider	Requesting provider is instructed to file an appeal on behalf of the member or submit a claim and follow the provider appeal/reconsideration/dispute process.

Timeframe Requirements for Peer-to-Peer Review Note: One Peer-to-Peer discussion is allowed for each adverse determination.		
	Medicaid/Marketplace	**Medicare**
	appeal/ reconsideration/ dispute process.	

Timeframe Requirements for Submission of Additional Information Following the Peer to Peer		
	Medicaid/ Marketplace	**Medicare**
	Pre-Service	
After discussing the case with requesting provider, Molina Medical Director requests that additional information be submitted to Molina, following the Peer-to-Peer:	Additional information must be received by the requesting provider within **one (1) business day** following the Peer-to-Peer discussion.	Prior to an adverse determination being made, additional information must be received by the requesting provider within **one (1) business day** following the Peer-to-Peer discussion. Once an adverse determination has been made, additional information cannot be accepted.
	If the provider does not meet the above timeframe for submitting additional information: Molina will notify the provider stating that: ✓ The initial decision will be upheld and Instruct the provider to file an appeal on behalf of the member or submit a claim and file a claims dispute/reconsideration.	Prior to an adverse determination being made, if the additional information is received **AFTER 1 business day** following the peer to peer Molina will notify the provider stating that ✓ The information cannot be accepted. ✓ The adverse determination will be issued, and the provider may file an appeal on behalf of the member or submit a claim and file a claims dispute/reconsideration.

There are circumstances where a Peer-to-Peer conversations will not be initiated. These are listed below:

Medicaid/ Marketplace	**Medicare**

✓ A request was administratively denied (e.g. non-covered benefit or exhaustion of benefits) ✓ An appeal has been submitted and filed ✓ A peer to peer, for the same denial, has already occurred. ✓ Post Service requests: services have been rendered (provided) ✓ If the peer to peer is requested after 5 business days from receipt of the denial notification for a pre-service request.	✓ Concurrent requests (concurrent review): The member has been discharged ✓ A request was administratively denied (e.g. non-covered benefit or exhaustion of benefits) ✓ An appeal has been submitted and filed
If any of the above apply Molina will notify the provider that: ✓ The initial decision will be upheld at this time; ***and*** ✓ Instruct the provider that a member appeal or claims dispute may be filed	

Requesting Prior Authorization

Notwithstanding any provision in the Provider's Agreement with Molina that requires 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 Authorization tools located on the MolinaHealthcare.com website:

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

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Molina website at MolinaHealthcare.com.

Availity Essentials portal: Molina is a Digital First organization for authorization submissions and phone or fax-based submissions may not be available in certain markets. Participating Providers should use the Availity Essentials portal for prior authorization submissions whenever possible. 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. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

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

- Access prior authorization letters directly through the new Digital Correspondence Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.

Digital Correspondence Hub
The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.

Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not realtime alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

Phone: Prior authorizations can be initiated by contacting Molina's Healthcare Services department at (855) 322-4077. It may be necessary to submit additional documentation before the authorization can be processed.

Evolent: Radiology Benefit Management (Advanced Imaging) Program: Molina collaborates with Evolent to conduct medical necessity review on certain prior authorization (PA) requests. For information on Evolent Radiology Benefit Management (Advanced Imaging) Program, please refer to **Appendix A** at the end of this section.

ProgenyHealth: Neonatal Intensive Care Unit (NICU) Admission and Concurrent Review Program: Molina collaborates with ProgenyHealth for neonatal care management services provided to premature and medically complex newborns in the Neonatal Intensive Care Unit (NICU). For information on ProgenyHealth, please refer to **Appendix B** at the end of this section.

TurningPoint Comprehensive Condition Management – Musculoskeletal Program: Molina has contracted with TurningPoint to provide an innovative solution to work collaboratively with providers, facilities, and physicians to reduce treatment variability, promote safety, quality of care improvements, and support for <Molina> members. For information on TurningPoint, please refer to **Appendix C** at the end of this section.

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.

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying Medical Groups/IPAs or other delegated entities. They must have the ability to perform the delegated activities and maintain specific delegation criteria 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.

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 322-4077 during normal business hours, Monday through Friday (except for holidays) from 8:00 a.m. to 5:00 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 Nurse Advice Line is available to members 24 hours a day, 7days a week at (888) 275-8750 Molina's Nurse Advice Line may handle after-hours UM calls.

Emergency Services

Emergency Services means healthcare services needed to evaluate, stabilize, or treat an Emergency Medical Condition.

Emergency Medical Condition or Emergency means the sudden onset of a medical, psychiatric, or substance abuse condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily functions, or serious dysfunction of any bodily organ or part.

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

Emergency Services are covered on a 24-hour basis without the need for prior authorization for all members experiencing an Emergency Medical Condition.

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 in-patient admission as a Post Stabilization service must request this type of service by contacting Molina at (855) 322-4077.

Inpatient admission requests (not including Post Stabilization requests) received via fax or the Availity Essentials portal will be processed within standard Inpatient regulatory and contractual time frames.

Molina provides Members with a 24-hour Nurse Advice Line for medical advice. 911 information is also given to all members at the onset of any call to the plan.

For members within our service area, Molina contracts with vendors that provide 24-hour Emergency Services for ambulance and hospitals. An out-of-network emergency hospital stay may only be covered until the Member has stabilized sufficiently to transfer to a participating facility

Molina Care Managers will contact members over-utilizing the emergency department to provide assistance whenever possible and determine the reason for using Emergency Services.

Care Managers will also contact the PCP to ensure that members are not accessing the emergency department because of an inability to be seen by the PCP.

Inpatient Management

Planned Admissions

Molina requires prior authorization for all elective inpatient procedures to any facility. Facilities are required to notify Molina within twenty-four (24) hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within two (2) business days of admission. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Molina requires that notification includes member demographic information, facility information, date of admission and clinical information sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all the needed clinical documentation to support the need for an inpatient may result in a denial of authorization for the inpatient stay.

Inpatient concurrent stay reviews are completed at the time of hospitalization to review the medical necessity for the admission, do not dictate the care needed by the member and are not considered a prior authorization. If the admission does not meet medical necessity criteria for an inpatient setting, the facility can bill for an observation stay.

Effective October 1, 2015, the diagnoses referenced in MSA bulletin 15-32 will be considered payable at the Michigan Department of Health and Human Services one day/observation rate for stays in the observation or inpatient setting for admission and discharge the same calendar day or next calendar day. Consistent with the MDHHS short stay policy, facilities should bill either an inpatient admission or an outpatient observation stay depending on the medical necessity of the case. Molina will not conduct a concurrent stay review for inpatient authorization because the claim will be paid at the same rate for either an inpatient or observation stay. No approval is required for these cases.

MDHHS Bulletin 15-32

Inpatient at time of Termination of Coverage

When a member's coverage with Molina terminates during a hospital stay, Molina will continue to cover services through discharge unless Law or program requirements mandate otherwise.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure the medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated clinical records from inpatient facilities at regular intervals during a member's inpatient stay.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the provider contract terms and agreements.

Molina will authorize hospital care as inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. Upon discharge the provider must provide Molina with a copy of member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Molina's UM staff follow federal and state guidelines along with evidence-based criteria to determine if the submitted clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and medical necessity requirements (refer to the Medical Necessity Review subsection of this Provider Manual).

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 closely with the hospital discharge planners to determine the most appropriate discharge setting for Molina members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility, and rehabilitative services.

Readmissions

Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

A readmission is defined as any admission within fifteen (15) days of a previous discharge, whether the readmission is to the same or different hospital.

If a readmission is to the same hospital within fifteen (15) days for a related condition, the admission and readmission are considered as one episode.

If a readmission is to a different facility within fifteen (15) days of discharge, and it is determined that the readmission is related to the first admission, a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
  - Premature or inadequate discharge from the same hospital
  - Issues with transition or coordination of care from the initial admission
  - For an acute medical complication plausibly related to care that occurred during the initial admission
- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple traumas, and burns
  - Neonatal and obstetrical readmissions
  - Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed
  - Mental Health readmissions
  - Transplant related readmissions

Post Service Review

Failure to obtain authorization when required may result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known

that patient was a Molina member or there was a Molina error. In those cases, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical necessity.

Specific Federal or State requirements or provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement About Incentives

All medical decisions are coordinated and rendered by qualified practitioners and licensed staff unhindered by fiscal or administrative concerns. Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to members.

Molina requires that all utilization-related decisions regarding member coverage and/or services are based solely on appropriateness of care and existence of coverage. Molina does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-Network Providers and Services

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

Avoiding Conflict of Interest

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

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.

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.

Molina staff provide 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.

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 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 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 up to ninety (90) days or longer, if necessary, for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester 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) 322-4077.

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 mental 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 themself, or unable to protect themself 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 childcare 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
Michigan Department of Health and Human Services, Child Protective Services, (855) 444-3911

Adult Abuse
Michigan Department of Health and Human Services, Adult and Children Services, (855) 444-3911

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.

PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member. The case manager provides the PCP with the member's individualized care plan (ICP), interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the ICP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager Responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop an ICP that includes recommended interventions from Member's ICT, as applicable. ICP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the care manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the member to determine member needs

- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as the member's needs warrant
- Serves as a coordinator and resource to the member, their representative and ICT participants throughout the implementation of the ICP, and revises the plan as suggested and needed
- Coordinates appropriate education and encourages the Member's role in self-management
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program

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. Level 1 Members can be engaged in the program for up to ninety (90) days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

Molina offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings via Health Risk assessments and Identification and Stratification. Members can request to be enrolled or disenrolled in these programs at any time. The chronic conditions programs include:

- Asthma
- Depression
- Diabetes
- COPD
- Heart Failure
- Hypertension

Molina healthy lifestyle programs include:

- Weight Management
- Tobacco Cessation
- Nutrition consult

For more information about these programs, please call (833) 269-7830 (main line) or (866) 472-9483 (health lifestyle programs), TTY/TDD: 711 or fax at (800) 642-3691.

Maternity Screening and High-Risk Obstetrics

Molina offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high-risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for Members with identified high-risk pregnancies to assure best outcomes for Members and their

newborns during pregnancy, delivery and through their sixth week post-delivery. Pregnant Member outreach, screening, education and care management are initiated by Provider notification to Molina, Member self-referral and internal Molina notification processes. Providers can notify Molina of pregnant/high-risk pregnant Members via faxed Pregnancy Notification Report Forms.

Pregnancy Notification Process

The PCP shall submit to Molina the Pregnancy Notification Report Form (available at MolinaHealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (844) 861-1932.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Molina mobile app.

Program Eligibility Criteria and Referral Source

Health Management (HM) Programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact Molina Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications
- Encounter Data or paid Claims with a relevant CMS-accepted diagnosis or procedure code
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants Eligible Members are referred to the program registry
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled Members
- External referrals from Provider(s), caregivers or community-based organizations
- Internal referrals from Nurse Advice Line, Medication Management, or Utilization Management
- Member self-referral due to general plan promotion of program through Member newsletter or other Member communications

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease
- Clinical resources such as patient assessment forms and diagnostic tools
- Patient education resources
- Provider Newsletters promoting the Health Management Programs, including how to enroll patients and outcomes of the programs
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on Health Management Programs is available from your local Molina Healthcare Services department.

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 Contact Center.

Specialty Providers

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.

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 prior authorization from Molina.

Care Management (CM)

Molina provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina care managers may be licensed professionals and are educated, trained, and experienced in Molina's ICM program. The ICM program is based on a Member advocacy

philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina care manager will complete an assessment with the member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina care manager is responsible for assessing the member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, ancillary providers, the local Health Department, or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care, and social data about the Member being referred.

Members with the following conditions may qualify for Care Management and should be referred to the Molina ICM Program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, CHF, etc.)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing emergency department services inappropriately
- Children with Special Health Care Needs

To make a referral to the Molina RN Case Management team, please send email to: CMescalationsMI@molinahealthcare.com
Include member name, date of birth, and reason for referral.

Or you can contact Molina at:

Phone: (855) 322-4077
Fax: (800) 594-7404

Appendix A: Evolent: Radiology Benefit Management (Advanced Imaging)

Evolent: Radiology Benefit Management (Advanced Imaging)

Molina collaborates with Evolent to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating and non-participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for Molina adult and pediatric Members.

Evolent conducts reviews for the following professional services:

Advanced Radiology services:

- CT/CTA
- MRI/MRA
- PET Imaging
- Additional advanced imaging CPT codes identified in the RBM code matrix

Please consult the PA Lookup Tool for further guidance on where to submit professional services PA requests.

Evolent: PA request submission

The requesting Provider must complete a PA request using one of the following methods:

- For Providers' convenience, logging into the Evolent online portal is the preferred submission method: Welcome to RadMD.com | RADMD
  - Evolent's online portal functionality offers instant approvals for PA requests
- Evolent telephonic request lines
  - Medicaid: (800) 442-4169
- Evolent Fax intake: (800) 784-6864
-

Evolent: peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

Appendix B: ProgenyHealth: Neonatal Intensive Care Unit (NICU) Admission and Concurrent Review Program and Process

Molina collaborates with ProgenyHealth for neonatal care management services provided to premature and medically complex newborns in the Neonatal Intensive Care Unit (NICU).

All NICU utilization management functions including initial admissions, continued stay requests, discharge planning, and all readmissions up to 60 days post-discharge of the initial NICU discharge will be managed by ProgenyHealth. Providers must submit NICU authorization requests and clinical documentation supporting the NICU stay to ProgenyHealth directly.

- Phone: (888) 832-2006
- UM Email: MolinaMIUM@progenyhealth.com
- CM Email: MolinaMICM@progenyhealth.com
- Website: ProgenyHealth.com

For all infants born and/or admitted to the NICU, NICU Notification of Admission must be faxed directly to ProgenyHealth at (866) 890-8857. The following information must be included:

- Mother's Name, Date of Birth, Member ID number
- Infant Name (if known) and Member ID number (if known)
- Attending Physician NPI number
- Facility NPI number

ProgenyHealth: Peer-to-peer review

- Peer-to-peer may be requested with a ProgenyHealth Medical Director by calling (888) 832-2006 and following the Physician Advisor's prompt and directions.
- If peer-to-peer is declined or if the denial determination is upheld, providers would follow Molina's appeal process if not in agreement with the determination.

ProgenyHealth: Transfers and readmissions

- ProgenyHealth will manage infants transferred from the NICU to another acute care facility under the guidance of Molina's current rules for higher, lateral, and lower-level care transfers.
- ProgenyHealth will manage emergent readmissions for all infants managed by ProgenyHealth for their initial NICU admission if readmitted within the first 60 days after the **initial** NICU discharge date.

ProgenyHealth: Utilization Management Cases

- All concurrent stay reviews and discharge summaries should be faxed directly to ProgenyHealth.

ProgenyHealth: Care Management Program Review

- Families will have a dedicated Case Manager who will provide support and education.
- Following notification of NICU admission, ProgenyHealth outreaches caregivers for early inpatient engagement to evaluate Social Determinants of Health and barriers to safe discharge home.

- ProgenyHealth Case Managers will continue to follow Molina Members for 60 days from the **initial** NICU discharge date.

- ProgenyHealth Case Managers, Social Workers, and Care Coordinators assist Molina Members with identifying support and utilizing national and local community resources.
  - Identifying PCP
  - Behavioral health support
  - Lactation services/obtaining a breast pump
  - Transportation resources

ProgenyHealth will collaborate with facility CM for infants with anticipated discharge needs, complex medical care, or considerable social situations.

Appendix C: TurningPoint Comprehensive Condition Management: Musculoskeletal Surgical Quality and Safety Program

Molina has contracted with TurningPoint to provide an innovative solution to work collaboratively with providers, facilities, and physicians to reduce treatment variability, promote safety, quality of care improvements, and support for Molina members. As part of this program, Molina has delegated its utilization management function to TurningPoint for a limited scope of procedures outlined below:

Orthopedic Surgical Procedures Including all associated partial, total, and revision surgeries:	**Spinal Surgical Procedures** Including all associated partial, total, and revision surgeries:

• Knee Arthroplasty
• Unicompartmental/Bicompartmental Knee Replacement
• Hip Arthroplasty
• Shoulder Arthroplasty
• Elbow Arthroplasty
• Ankle Arthroplasty
• Wrist Arthroplasty
• Acromioplasty and Rotator Cuff Repair
• Anterior Cruciate Ligament Repair
• Knee Arthroscopy
• Hip Resurfacing
• Meniscal Repair
• Hip Arthroscopy
• Femoroacetabular Arthroscopy
• Ankle Fusion
• Shoulder Fusion
• Wrist Fusion
• Osteochondral Defect Repair
	• Spinal Fusion Surgeries
	  ○ Cervical
	  ○ Lumbar
	  ○ Thoracic
	  ○ Sacral
	  ○ Scoliosis
	• Disc Replacement
	• Laminectomy/Discectomy
	• Kyphoplasty/Vertebroplasty
	• Sacroiliac Joint Fusion
	• Implantable Pain Pumps
	• Spinal Cord Neurostimulator
	• Spinal Decompression

Prior Authorization is required for inpatient, outpatient, and doctor's office settings for these procedures. Clinical coding specific to the procedures included in the program may be accessed using the provider auth tool at PA Lookup Tool. Please note the coding is subject to regular updates/changes as CPT/HCPCS coding is added or deleted.

Turningpoint: utilization management and precertification contact information

TurningPoint requests a digital-first approach, with case submissions expected to be submitted through the provider portal whenever feasible. TurningPoint's provider portal can be accessed at https://myturningpoint-healthcare.com.

TurningPoint is available at (866) 422-0800, 5 am – 5 pm of each normal business day in each time zone where TurningPoint conducts its review activities. In the event a provider needs to contact TurningPoint for prior authorization after hours or on weekends, TurningPoint has medical professionals on-call 24 hours a day, 7 days a week.

Turningpoint: peer-to-peer review

Peer to peer reviews are unique in that they are conducted by specialized physicians in accordance with the procedure.

- Medicaid: peer-to-peer reviews are offered for reconsideration of final determinations to allow for review of supporting clinical documentation

Providers can initiate a peer-to-peer conversation with a TurningPoint Medical Reviewer by contacting TurningPoint's Peer to Peer Department at (800) 581-3920.

QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Molina Quality department **toll free at** (855) 322-4077 or fax (844) 861-1932.

The address for mail requests is:
Molina Healthcare of Michigan, Inc.
Quality Department
1201 Woodward Avenue, Suite 900
Detroit, MI 48226

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 Manager 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 (QIP) in place
- Comply with and participate in Molina's QI 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, service, 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.

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."

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's medical 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 mental l 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 medical 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 twenty-four (24) hours
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when the 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 mental 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 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 mental 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 thirty (30) days of an 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 advance directives, power of attorney and living will have been discussed with Member, and a copy of advance directives when in place
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors
- Treatment plans that are consistent with diagnosis
- A working diagnosis recorded with the clinical finding
- 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 the facilitation of medical care

Retrieval

- The medical record is available to the 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 twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than ten (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
- Restrict access to computerized confidential information
- Take precautions to prevent inadvertent or unnecessary disclosure of protected health information
- Educate and train 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 is protected

Additional information on medical records is available from your local Molina Quality department. For additional information regarding HIPAA, please refer to the **Compliance** section of this Provider Manual.

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 two (2) types of Advance Directives:

- **Durable power of attorney for health care**: allows an agent to be appointed to carry out health care decisions
- **Living will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration

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 older, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

Members who would like more information are instructed to contact the Member Contact Center or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to 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.

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.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists) and mental health Providers. 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 twenty-four (24) hours a day, seven (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.

Medical Appointment - Medicaid

Emergency Services	Immediately 24 hours/ 7 days per week
Urgent Care	Within 48 hours
Routine Care	Within 30 business days of request
Non-Urgent Symptomatic Care	Within 7 business days of request
Specialty Care	Within 6 weeks of request
Acute Specialty Care	Within 5 business days of request
Mental Health	Routine care within 10 business days of request
	Non-life threatening emergency within 6 hours of request
	Urgent care within 48 hours of request
Prenatal Care – Initial Prenatal Appointment	If enrollee is in the first or second trimester: Within 7 business days of enrollee being identified as pregnant If enrollee is in the third trimester: Within 3 business days of enrollee being identified as pregnant
	If there is any indication of the pregnancy being high-risk (regardless of trimester): Within 3 business days

Dental Health Appointment - Medicaid

Emergency Dental Services	Immediately 24 hours/day 7 days per week
Urgent Dental Care	Within 48 hours
Routine Dental care	Within 21 business days of request
Preventive Dental Services	Within 6 weeks of request
Initial Dental Appointment	Within 8 weeks of request

Additional information on appointment access standards is available from the Molina Quality department.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 45 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 twenty-four (24) hour telephone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments.
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record.
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time.
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to, wheelchair-using Members and Members requiring language interpretation.
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited, to immunizations and mammograms.
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit their practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. If a PCP chooses to close their panel to new Members, Molina must receive 30 calendar day advance written notice from the Provider.

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.

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 Committee (QIC) 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, 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 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 Committee.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member appeals and complaints /grievances for all office sites to determine the need for 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 access 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 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 the 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 (2) 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 (1) CPR-certified employee is available
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with ten (10) or more employees
- A container for sharps is located in each room where injections are given
- Labeled containers, policies, contracts and 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

Early and periodic screening, diagnostic and treatment (EPSDT) Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all required Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services to Enrollees under twenty-one (21) years of age are timely according to required preventive guidelines. All Enrollees under twenty-one (21) years of age should receive preventive, diagnostic and treatment services at intervals as set forth in Section 1905 (R) of the Social Security Act. Molina's Quality or the Provider Relations departments are also available to perform Provider training to ensure that best practice guidelines are followed in relation to well child services and care for acute and chronic health care needs.

Well Child/Adolescent Visits

Visits consist of age-appropriate components, that include but are not limited to:

- Comprehensive health and developmental history
- Nutritional assessment
- Height and weight and growth charting
- Comprehensive unclothed physical examination
- Appropriate immunizations according to the Advisory Committee on Immunization Practices
- Laboratory procedures, including lead blood level assessment appropriate for age and risk factors
- Periodic developmental and behavioral screening using a recognized, standardized developmental screening tool
- Vision screening for preventive services. Only medically necessary services are covered. Pediatric routine vision services (one (1) eye exam per year) are accessed by Members through the VSP Vision Care network
- Dental assessment and services
- Health education, including anticipatory guidance such as child development, healthy lifestyles, accident and disease prevention
- Periodic objective screening for social emotional development using a recognized, standardized tool
- Perinatal depression for mothers of infants in the most appropriate clinical setting, e.g., at the pediatric, mental health or OB/GYN visit

Diagnostic services, treatment, or services Medically Necessary to correct or ameliorate defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment must be provided if within the Member's Covered Benefit Services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

Molina shall have no obligation to pay for services that are not Covered Services.

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 that the Provider submit a written corrective action plan to Molina within thirty (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.

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 QI program. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; 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 Care Services section of this Provider Manual.

Clinical Practice Guidelines

Molina adopts and disseminates Clinical Practice Guidelines (CPG) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority.

Molina CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care
- Hepatitis C

All CPGs are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year, CPGs are distributed to Providers at www.molinahealthcare.com/providers/mi/medicaid/resource/guide_clinical.aspx and the Provider Manual.

Notification of the availability of CPGs 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 the 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). Links to current recommendations are included on Molina's website.
- 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 Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, or when changes are made during the year, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com 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 (CLAS)

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.

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®)
- Mental Health Satisfaction Assessment
- Provider Satisfaction Survey
- Effectiveness of quality improvement initiatives

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 Agreement with Molina. 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.

CAHPS ® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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, preventive health screenings, 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 to 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.

Mental Health Satisfaction Assessment

Molina obtains feedback from Members about their experience, needs, and perceptions of accessing mental 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.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS® 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 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® survey Star Ratings measures, contact your local Molina Quality department.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
CAHPS ® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

MENTAL HEALTH

Overview

Molina provides a mental health benefit for Members. Molina takes an integrated, collaborative approach to mental health care, encouraging participation from PCPs, mental health, and other specialty 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 mental health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Treatment for long-term, severe mental health and substance use conditions including inpatient, intensive outpatient and residential treatment are carved out from the health plan. These services are arranged and provided through the Prepaid Inpatient Health Plans (PIHPs). Providers should follow the MDHHS Medicaid Provider Manual for direction on authorization through the PIHPs or MDHHS for substance abuse services.

Access to Mental Health Providers and PCPs

Members may be referred to an in-network Mental Health Provider for outpatient services via referral from a PCP, medical specialist or by Member self-referral. PCPs, Qualified Mental Health Professionals, and Qualified Intellectual Disability Professionals are able to screen and assess Members for the detection and treatment of any known or suspected mental health problems and disorders. PCPs may provide any clinically appropriate mental 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 or mental health Provider. However, individual services provided by non-network behavioral health Providers will require PA prior authorization.

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

Provider Responsibilities for Mental Health Assessment

Molina supports the MDHHS Mental Health Framework (MHF) allowing Qualified Mental Health Providers including Child Mental Health Professionals (CMHPs), Qualified Mental Health Professionals (QMHPs), and Qualified Intellectual Disability Professionals (QIPDs), whose scope of practice includes assessment of mental health needs, who participate with Medicaid and Molina must:

1. Providers must complete applicable MichiCANS and LOCUS training.

2. Conduct Standardized Assessments at intake, annually, or upon change in condition as defined by MDHHS Standardized Assessment Guide.
3. Submit results in CHAMPS within 24 hours of completion and submission by the provider.
4. Support Molina's and MDHHS fidelity monitoring, responding to notifications for annual assessments.

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential mental health facility. Members who were admitted to an inpatient or residential mental health setting must have an adequate outpatient follow-up appointment scheduled with a mental health Provider prior to discharge and to occur within seven (7) days of discharge.

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 treatment team. Mental 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 the 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 mental 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 mental health professional or PCP to the care management program.

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 Molina 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.

Referrals to the care management program may be made by contacting Molina at:

Phone: (855) 322-4077
Email: CMescalationMI@MolinaHealthCare.com

For additional information on the ICM program please refer to the Care Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of Mental Health Providers

Molina promotes collaboration with Providers and integration of both physical and mental health services in an effort to provide quality care coordination to Members. Mental health Providers are expected to provide in-scope, evidence-based outpatient mental health services to Molina Members. Mental health Providers may only provide physical health care services if they are licensed to do so. Please note that inpatient mental health and all substance abuse services are carved out from the health plan. Responsibilities are determined by the PIHPs and/or MDHHS for these services.

Providers shall follow Quality standards related to access. 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 (7) days of the discharge date. If a Member misses a mental health appointment, the mental health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Mental Health Crisis Line

Molina has a Mental Health Crisis Line that may be accessed by Members 24/7 year-round. The Molina Mental Health Crisis Line is staffed by mental 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 Mental Health Crisis Line by calling the Nurse Advice Line telephone number at (888) 275-8750 (English) (866) 648-3537 (Spanish) TTY/TDD English: (866) 735-2929 TTY/TDD Spanish: (866) 833-4703.

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.

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 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.

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

COMPLIANCE

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, detection, and correction along with the education of appropriate employees, vendors, Providers and associates doing business with Molina.

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

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any federally funded contract or program. 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 or 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
- Administrative remedies for false Claims and statements

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. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which Molina has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to Molina.

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.

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 Molina 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 forms 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 of 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

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

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

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

Examples of Fraud, Waste, and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement
- Balance billing a Molina Member for Covered Services; this includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees
- Billing and providing for services to Members that are not medically necessary
- Billing for services, procedures and/or supplies that have not been rendered
- Billing under an invalid place of service in order to receive or maximize reimbursement
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider
- Concealing a Member's misuse of a Molina identification card
- Failing to report a Member's forgery or alteration of a prescription or other medical document

- False coding in order to receive or maximize reimbursement
- Inappropriate billing of modifiers in order to receive or maximize reimbursement
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients
- Not following incident -to-billing guidelines in order to receive or maximize reimbursement
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges
- Questionable prescribing practices
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code
- Underutilization, which means failing to provide services that are medically necessary
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more
- Using the adjustment payment process to generate fraudulent payments

Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider Claims and Claims System

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

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

The 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 the 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.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Molina, Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

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.

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, the 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 SIU 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 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

Suspected cases of fraud, waste, or abuse must be reported to Molina by contacting the Molina AlertLine. The Molina AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. The Molina AlertLine telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the Molina AlertLine, a trained professional at NAVEX Global will note the caller's concerns and provide them to the Molina Compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina AlertLine can be reached at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com.

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

Molina Healthcare of Michigan, Inc.
Attn: Compliance
1201 Woodward Ave Ste. 900
Detroit, MI 48226

Email: mhmcompliance@molinahealthcare.com

The following information must be included 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

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

www.michigan.gov/mdhhs/assistance-programs/cash/cust-app/eligibility/complaints

Department of Health and Human Services

Office of Inspector General
P.O. Box 30062
Lansing, MI 48909
Phone: 855-MI-FRAUD (643-7283)

Online: www.michigan.gov/fraud

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).

Provider Responsibilities

Molina expects that its contracted Provider 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 their PHI and includes a summary of how Molina safeguards their PHI.

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

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

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 the 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.

Uses 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] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule

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

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

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

Importantly, this allows Providers to share PHI with Molina for our health care operations activities, such as HEDIS® and quality improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patient Records regulations 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 treatment. Records of the identity, diagnosis, prognosis or treatment of any patient which are maintained in connection with substance use disorder treatment or programs "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, the federal confidentiality of substance use disorder patient records regulations are42 CFR Part 2 is more restrictive than HIPAA and they do does not allow disclosure without the Member's 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.

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

Inadvertent Disclosures of PHI

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

Written Authorizations

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

Patient Rights

Patients are afforded various rights under HIPAA. 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 for additional information regarding HIPAA standard transactions.

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

Code Sets

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

National Provider Identifier (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 thirty (30) days and should also be reported to Molina within thirty (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 and Atypical Providers

Providers that are delegated for Claims and Utilization Management activities ("Delegated Providers") are the "Business Associates" of Molina for the delegated functions performed on behalf of Molina. Providers that provide services to Molina members but who are not health care providers under HIPAA ("Atypical Providers") are the Business Associates of Molina. Under HIPAA, Molina must obtain contractual assurances from all Business Associates that they will safeguard Molina Member PHI. Delegated Providers and Atypical Providers must agree to various contractual provisions required under HIPAA's privacy and security rules, including entering into a Business Associate Agreement with Molina. Delegated Providers and Atypical Providers agree to comply with the following HIPAA Business Associate Agreement requirements.

HIPAA required business associate agreement

Applicability: This HIPAA Required Business Associate Agreement ("BAA") sets forth the requirements with which the Business Associate must comply when it receives or has access to Protected Health Information ("PHI") in the performance of Services under the Agreement(s) and with respect to that PHI.

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Covered Entity," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the Provider subject to this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in

any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Covered Entity" or "Molina" shall mean Molina Healthcare of Michigan.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Party or Parties" shall mean Covered Entity and Business Associate who parties to this BAA.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use, maintenance, transmission, or disclosure of PHI, the services provided by the Business Associate to Molina under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 USC §290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2").

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. General provisions

2.1. Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by Molina to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2. Amendment. Molina may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon 45 business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. Molina may otherwise materially amend this BAA only after 45 business days prior written notice to the Business Associate and only if mutually agreed to by the Parties as evidenced by the amendment being

executed by each Party hereto. If the Parties fail to execute a mutually agreeable amendment within 45 days of the Business Associate's receipt of Molina's written notice to amend this BAA, Molina shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of Molina.

3. Scope of use and disclosure

3.1. The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2. The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by Molina, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and
b. to provide Data Aggregation services relating to the Health Care Operations of Molina if required under the Agreement.

3.3. The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or
b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4. The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, Molina, is as between the Parties, the sole property of Molina.

3.5. The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of Molina in each instance. Further, the Business Associate or its agents or Subcontractors shall not transmit or store PHI outside of the United States of America without Molina's prior written consent.

3.6. The Business Associate agrees to be fully bound by the requirements of 42 CFR Part 2 upon receipt of any SUD Records disclosed under this Agreement. The Business Associate shall not use or disclose SUD Records except as necessary for the Business Associate to perform Services. The Business Associate shall not redisclose any SUD Records to a third party, except to a contract agent acting on the Business Associate's behalf to provide Services or back to Molina. The contract agent may only redisclose such information to the Business Associate or Molina. The Business Associate and any contract agent shall not disclose SUD Records for use in any civil, criminal, administrative or legislative proceeding against the individual who is the subject of the

SUD Record and shall immediately notify Molina of any such request. The Business Associate must ensure that any such contract agent agrees in writing to these same restrictions and obligations set forth in this Section.

4. Obligations of the business associate

The Business Associate shall:

4.1. Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2. Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Molina. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4. Promptly report to Molina any unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI, Breach of Unsecured PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such unauthorized use or disclosure, Breach of Unsecured PHI, or Security Incident. The Business Associate shall indemnify Molina against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI and the provision of two years of credit monitoring and identity protection services to the affected individuals. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5. The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify Molina of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than 30 days after the discovery of the Breach. The notification by the Business Associate to Molina shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that Molina is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;
b. a description of the types of Unsecured PHI that were involved in the Breach; and
c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7. Within 10 days of receiving a request, make available PHI in a Designated Record Set to Molina as necessary to satisfy Molina's obligations under 45 CFR 164.524.

4.8. Within 15 days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by Molina pursuant to 45 CFR 164.526.

4.9. Maintain and make available to Molina, within 20 days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy Molina's obligations under 45 CFR 164.528.

4.10. Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of Molina available to Molina or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11. To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of Molina, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12. To the extent the Business Associate is to carry out one or more of Molina's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to Molina in the performance of such obligation(s).

5. Miscellaneous

5.1. Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2. Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3. No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4. Governing Law and Venue. This BAA shall be governed by Michigan law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by Molina.

5.5. Compliance with Confidentiality Laws. The Business Associate acknowledges that it must comply with all applicable laws that may protect the confidentiality of PHI or other personally identifiable information received and will comply with all such laws.

5.6. Notices. Any notices to be given hereunder to Molina shall be made via certified U.S. Mail or express courier to Molina's address given below, and/or (other than for the delivery of fees) via email to the email listed below:

Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802
Attn: Privacy Official
Email: PrivacyOfficial@MolinaHealthcare.com

6. Term and termination of BAA

6.1. Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date Molina terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2. Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), Molina may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if Molina determines, in its sole discretion, that Business Associate has violated a material term of this BAA.

6.3. Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to Molina or, if agreed to by Molina, destroy all PHI received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide Molina with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required by Law. If return or destruction of all PHI, and all copies of PHI, received from Molina, or created, maintained, or received by Business Associate on behalf of Molina, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and
b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4. Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

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

Information Security and Cybersecurity

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 (2) 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 Agreement 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 the Provider, the Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

iii. The 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. The Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. The 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 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 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 24 hours following such payment.

ii. Within 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 Agreement 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 Agreement.

6. Other Provisions. The Provider acknowledges that there may be other information security and data protection requirements applicable to the Provider in the performance of services which may be addressed in an agreement between Molina and the 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 the Provider, the stricter of the conflicting provisions will control.

CULTURAL AND LINGUISTICALLY APPROPRIATE 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. Additional information on culturally and linguistically appropriate services is available at MolinaHealthcare.com, on the Availity Essentials portal (Go to Payer spaces, Resources Tab), from local Molina Provider relations representatives or by calling Molina Provider Contact Center at (855) 322-4077.

Nondiscrimination in Health Care Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557 of the ACA.
You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Handbook located at www.molinahealthcare.com/members/mi/en-us/mem/medicaid/overvw/handbook.aspx
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services at no cost. A sample of the Tagline Document that you will post can be found in the Member Handbook located at www.molinahealthcare.com/members/mi/en-us/mem/medicaid/overvw/handbook.aspx

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 is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index Limited English Proficiency (LEP) | HHS.gov and hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/indexLimited English Proficiency Resources for Effective Communication | HHS.gov. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina's Civil Rights Coordinator or the HHS-OCR:

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

If you or a Molina Member need additional help or more information, call the Office of Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697 for persons with hearing impairment.

Culturally and Linguistically Appropriate Services

Molina is committed to reducing health care disparities and improving health outcomes for all Members. 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. Molina integrates culturally and linguistically appropriate services 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 Services 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. On-site culturally and linguistically appropriate practices training
3. Online culturally and linguistically appropriate practices Provider training modules
4. Integration of culturally and linguistically appropriate practices and concepts and nondiscrimination of service delivery into Provider communications

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 Limited English Proficiency (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.

Access to Language Services

Providers may request interpreters for Members who speak a language other than English by calling Molina's Member Contact Center toll free at (888) 898-7969. If Molina Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified interpreter.

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 with 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, 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 or inability 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 Managers trained to work with individuals with cognitive impairments
- 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 on-site, video remote or telephone interpreter services
    - Providers needing assistance obtaining written materials in preferred languages

- Providers with Members who cannot hear or have limited hearing ability may use the National TTY/TDD Relay service 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
- The Molina Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version

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 Molina's internal staff or someone from a commercial interpreter service vendor (Information should include the interpreter's name, operator code, and vendor)
- Document all counseling and treatment done using interpreter services
- Document if a Member insists on using a family member, friend, or minor as an interpreter, or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost

Members Who Are Deaf or Hard of Hearing

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

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

Molina will provide on-site or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via the Molina Member Contact Center.

24-hour Nurse Advice Line

Molina provides nurse advice services for Members twenty-four (24) hours per day, seven (7) days per week. The 24-hour Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly at (888) 275-8750 (English) (866) 648-3537 (Spanish) TTY/TDD 711.

The Nurse Advice Line telephone numbers are also printed on Member ID cards.

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
- Revalidate data at least annually
- 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® survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

MEMBER RIGHTS AND RESPONSBILITIES

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Member Handbook and on the Molina website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Handbook can be found on the Member pages of Molina's website at www.molinahealthcare.com/members/mi/en-us/mem/medicaid/overvw/handbook.aspx.

The most current Member Rights and Responsibilities can be found on the Member pages of Molina's website at www.molinahealthcare.com/members/mi/en-us/mem/medicaid/overvw/handbook.aspx.

Member Handbooks are available on Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "Rights and Responsibilities" within the Member Handbook document.

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) 322-4077, Monday - Friday 8:00 am - 5:00 pm., local time. TTY/TDD users, please call 711. Members may contact our Member Services team at (888) 898-7969.

Second Opinions

If Members do not agree with their Provider's plan of care, they have the right to a second opinion from another Provider. Members should call Member Services at (888) 898-7969 (TTY:711), Monday - Friday 8:00 a.m. - 8:00 p.m. to find out how to get a second opinion. Second opinions may require Prior Authorization.

BENEFITS AND COVERED SERVICES

This section provides an overview of the medical benefits and Covered Services for Molina Medicaid members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires Prior Authorization, please reference the Prior Authorization Lookup Tool located at on the Molina website and the Availity Essentials portal. You may also contact Molina at (855) 322-4077, seven (7) days a week, from 8:00 a.m. to 5:00 p.m., local time. TTY/TDD users, please call 711.

Member Cost Share

Providers should 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).

Service Covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires PA, please reference the Prior Authorization Lookup Tool located at on the Molina website and the Availity Essentials portal. You may also contact Molina at (855) 322-4077, seven days a week, from 8:00 a.m. to 5:00 p.m. local time local time TTY/TDD users, please call 711.

Link(s) to Benefit Information

The following web link provides access to the benefit information for the Medicaid program offered by Molina in Michigan.

www.molinahealthcare.com/members/mi/en-us/mem/medicaid/medicaid.aspx

Obtaining Access to Certain Covered Services

Non-preferred Drug Exception Request process

The Provider may request a prior authorization for clinically appropriate drugs that are not preferred under the Member's Medicaid Plan. Using the FDA label, community standards, and high levels of published clinical evidence, clinical criteria are applied to requests for medications requiring prior authorization.

- For a Pharmacy Exception Request, the Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision within twenty-four (24) hours of receiving the complete request
- If the initial request is denied, a notice of denial will be sent in writing to the Member and prescriber within twenty-four (24) hours of receiving the complete request

- Members will also have the right to appeal a denial decision, per any requirements set forth by MDHHS
- Molina will allow a seventy-two (72)-hour emergency supply of prescribed medication for dispensing at any time that a prior authorization is not available; pharmacists will use their professional judgment regarding whether or not there is an immediate need every time the seventy-two (72)-hour option is utilized (This procedure will not be allowed for routine and continuous overrides)

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.

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. Additional information about our Prior Authorization process, including a link to the PA request form, is available in the Pharmacy section of this Provider Manual. Physician administered drug claims require the appropriate National Drug Code (NDC) number 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.

Access to Mental Health Services

Mental health services are a direct access benefit and are available with no referral required. PCPs or health care professionals may assist members in finding amental health provider or members may contact Molina's Member Contact Center at (888) 898-7969. Molina's Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week for mental health or substance abuse needs. The services Members receive will be confidential.

Additional detail regarding Covered Services and any limitations can be obtained in the benefit information linked above, or by contacting Molina. If in-patient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation, and

inpatient Member cost share will apply.

Emergency Mental Health or Substance Abuse Services

Members are directed to call 988, 911 or go to the nearest emergency room if they need emergency mental health or substance abuse services. Examples of emergency mental health or substance abuse problems are:

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

Out of Area Emergencies

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

- Go to the nearest ER
- Call the number on the Molina Member ID card
- Call Member's PCP and follow-up within twenty-four (24) to forty-eight (48) hours

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

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.

Non-emergency Medical Transportation

For Molina Medicaid 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.). This requires a written prescription from the member's doctor. Examples of non-emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. Members require PA from Molina for ground and air ambulance services before the services are given. Prior Authorization not required for vans, taxi, etc. where they are covered benefits. Additional information regarding the availability of this benefit is available by contacting the Molina Provider Contact Center at (888) 898-7969.

Preventive Care

Preventive Care Guidelines (CPG) are located on the Molina website at www.molinahealthcare.com/members/mi/en-us/mem/medicaid/overvw/coverd/hm/hm.aspx

Providers can help by conducting these regular exams in order to meet the targeted State and Federal standards. Please call Molina's Health Education line at (855) 322-4077 with questions or suggestions related to well-child care.

Immunizations

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

Immunization schedule recommendations from the American Academy of Pediatrics 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).

Well Child Visits and Early Periodic Screening Diagnosis and Treatment (EPSDT) Guidelines

The Federal Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit requires the provision of early and periodic screening services and well care examinations to individuals from birth until twenty-one (21) years of age, with diagnosis and treatment of any health or mental health problems identified during these exams. The standards and periodicity schedule generally follow the recommendations from the AAP and Bright Futures. Additional information on EPSDT benefits covered by the Michigan State Department of Health and Human Services (MDHHS) is available at www.medicaid.gov/medicaid/benefits/epsdt/index.html.

The screening services include:

- Comprehensive health and developmental history (including assessment of both physical and mental health development)
- Immunizations in accordance with the most current Michigan Recommended or CDC Advisory Committee on Immunization Practices (ACIP) childhood immunization schedule, as appropriate
- Comprehensive unclothed physical exam
- Laboratory tests as specified by the AAP, including screening for lead poisoning
- Health education
- Vision services
- Hearing services
- Dental services

When a screening examination indicates the need for further evaluation, providers must provide diagnostic services or refer members when appropriate without delay. Providers must provide treatment or other measures (or refer when appropriate) to correct or ameliorate defects and physical and mental illness or conditions discovered by the screening services.

For children and youth in foster care younger than 21 years of age a full medical exam and behavioral health assessment is required by a PCP within the first 30 days of entering foster

care, regardless of when the last medical exam was done on the patient so that all concerns can be documented and addressed during the transition; the provider should bill for the appropriate EPSDT.

Providers can help conducting these regular exams in order to meet the MDHHS targeted State standard. Providers must use correct coding guidelines to ensure accurate reporting for EPSDT services. If you have questions or suggestions related to EPSDT or well childcare, please call Molina's Health Education line at (855) 322-4077 with questions or suggestions related to EPSDT or well-child care.

Maternal Infant Health Program (MIHP)

MIHP is a home visiting program for Medicaid eligible women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. The preventative services provided in this program include social work, nursing services, breast feeding support, nutritional counseling, and advocacy services. Molina requires MIHP provider organizations to be certified by MDHHS and adhere to the program policies, procedures, and expectations outlined in the Medicaid Policy, the MIHP Program Operations Manual and Public Act 291 of 2012.

Molina establishes and maintains agreements with certified MIHP provider organizations. MIHP providers enter into a coordination agreement as well as a provider services agreement to address the following program requirements:

- Medical coordination, including pharmacy and laboratory coordination
- Data and reporting requirements
- Quality assurance coordination
- Grievance and Appeal resolution
- Dispute resolution
- Transportation
- Member referral to an MIHP provider organization with thirty (30) days of MIHP eligibility determination, if the member is not already enrolled in another evidence-based home-visiting program
- Sufficient number of MIHP providers to meet member service and visitation needs within the required response time according to MDHHS MIHP protocols
- Service delivery response times

Molina requires all MIHP-eligible members be referred to an MIHP provider organization for MIHP outreach, screening and care coordination within one month of the effective date of MIHP eligibility determination if an Enrollee is not already enrolled in another evidenced based home visiting program.

- MIHP services are voluntary; Members will be provided an opportunity to select an MIHP provider organization

- If the member does not choose an MIHP provider organization at the time of MIHP eligibility determination, Molina will refer the member to an MIHP provider organization within one month of the effective date of MIHP eligibility determination

Molina incorporates the following provisions for MIHP for services and billing:

- Only one assessment is allowed per pregnancy and per infant
- Reimbursement is allowed for one professional visit per member per date of service, regardless of place of service
- Maternal members are only allowed up to nine (9) professional visits per pregnancy
    - Infant members are allowed up to nine (9) professional visits. With an accompanying physician order, infant beneficiaries may receive an additional nine (9) visits (for a total of 18). Provider should indicate they have a physician order using the MDHHS 5650 Communication Form. Provider should retain documentation of either the Communication Form or the Physician Order in their medical records.
    - For beneficiaries with a diagnosis of drug-exposed infant, these beneficiaries may receive the previously mentioned 18 visits, plus an additional 18 visits (for a total of 36 visits) with a physician order indicating this diagnosis and using the drug-exposed procedure code(s). Provider should indicate they have a physician order using the MDHHS 5650 Communication Form. Providers should retain documentation of either the Communication Form or the Physician Order in their medical records.

For more information, the MDHHS provider manual and MIHP Operations Guide can be found at: www.michigan.gov/mihp/0,5421,7-311-66378_66386_66387---,00.html.

To bill for MIHP services, contracted providers may submit all electronic claims using the Molina Healthcare Provider Portal at: www.availity.com.

To sign up for EFT, through ECHO Health, Inc. for Molina only, visit enrollments.echohealthinc.com/EFTERADirect/MolinaHealthcare.

If you have further question on how to register, please review our EFT FAQ sheet at www.molinahealthcare.com/providers/common/medicaid/ediera/era/faq.aspx.

Paper Claims may be submitted to the address below. **Please do not submit paper claims to the Molina Troy, Michigan Location as your claims will be returned.**

Molina Health Care
P.O. Box 22668
Long Beach, CA 90801

Current Medicaid policy does not require prior authorization for MIHP standard services. For transportation services, patients can call Member Services at (888) 898-7969 or Molina's transportation vendor.

Molina will fax or email the referrals to the contracted MIHP provider each month. The MIHP notifies the PCP when they enroll the member into their program. For questions, please email: MolinaMIHP@molinahealthcare.com* Fax: (844) 861-1932.
*We do not submit member information to public domain email addresses, i.e., Yahoo, Gmail, etc.

For claims questions and/or escalated issues, please email questions and issues to the MHMProviderServicesMailbox@molinahealthcare.com.

To make any updates or changes, please fill out our Provider Change Form located at: www.molinahealthcare.com/providers/mi/medicaid/forms/Pages/fuf.aspx.

To view the MIHP Webinar PowerPoint presentation, please visit www.molinahealthcare.com/providers/mi/medicaid/home

MIHP Contact Information:
Provider Contracting and Credentialing Email:
MHMprovidercontractingmailbox@molinahealthcare.com

Provider Services Email: MHMproviderservicesmailbox@molinahealthcare.com

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
9 months	1 visit a week

Emergency Services

Emergency Services means Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:

- Place the person's health in serious jeopardy, or
- Cause serious impairment to bodily functions, or
- Cause serious dysfunction of any bodily organ or part

Emergent care services are covered by Molina without PA. This includes non-contracted Providers inside or outside of Molina's service area.

24-hour Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

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)

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

Health Management Programs

Molina offers programs to help our members and their families manage various health conditions.

For additional information, please refer to the Health Care Services section of this Provider Manual.

Telehealth and Telemedicine Services

Molina Members may obtain physical and mental health 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
- Members have the option of receiving PCP services through telehealth; if they choose to
- use this option, the Member must use a Network Provider who offers telehealth
- 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 must be coded in accordance with applicable reimbursement policies and billing guidelines
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery

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

PROVIDER RESPONSIBILITIES

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination in health care service delivery requirements as 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's Civil Rights Coordinator.

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

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

For more information, please refer to the Department of Health and Human Services website 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) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794), that do not inhibit members with disabilities from obtaining all needed services from the provider by:

1. Providing flexibility in scheduling to accommodate the needs of Members
2. Ensuring that Members or individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include, but are not limited to,:

a. Providing large print (in a font size no smaller than 18 point) versions of all written materials to Members with visual impairments
b. Ensuring that all written materials are available in formats compatible with optical recognition software
c. Reading notices and other written materials to Members upon request
d. Assisting Members in filling out forms over the telephone
e. Ensuring effective communication to and from Members with disabilities through email, telephone, and other electronic means
f. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified American Sign Language interpreters for the deaf
g. Individualized forms of assistance
h. Ensuring safe and appropriate physical access to buildings, services, and equipment

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 an 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.

Please visit our Provider Online Directory at molina.sapphirethreesixtyfive.com/?ci=mi-molina&locale=en_us&network_id=21&geo_location=42.196978,-85.559906 to validate your information. Providers must validate their Provider information on file with Molina at least once every ninety (90) days for correctness and completeness.

Additionally, in accordance with the terms specified in your Provider Agreement, Providers must notify Molina of any changes, as soon as possible, but at a minimum thirty (30) calendar days in advance of any changes in any Provider information on file with Molina. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition of a Provider (within an existing clinic/practice)
- Change in Provider or practice name, Tax ID and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (PCPs only)
- Change in specialty
- 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.

Note: Some changes may impact credentialing. Providers are required to notify Molina of changes to credentialing information in accordance with the requirements outlined in the Credentialing and Recredentialing section of this Provider Manual.

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 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 the State's Medicaid Management Information System and meet the Medicaid Provider enrollment requirements set forth in the MDHHS guidelines for fee-for-service Providers of the appropriate provider type.

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

Molina Electronic Solutions Requirements

Molina requires 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 Claim submission, electronic fund transfers (EFT), electronic

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

Electronic Claims include Claims submitted via a clearinghouse using the 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 the Availity Essentials portal within thirty (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
- Electronic payment: EFT with ERA
- Availity Essentials portal: availity.com/providers

Electronic Claims Submission Requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enabling Claims to reach Molina faster

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Availity Essentials portal
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38334, refer to our website MolinaHealthcare.com for additional information

While both options are embraced by Molina, submitting Claims via the Availity Essentials portal (available to all Providers at no cost) offers a number of additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Availity Essentials portal Claims submission includes the ability to:

- Submit Claims through direct data entry
- Add attachments to Claims
- Submit Claims through quick Claims entry and saving templates
- Submit corrected Claims
- Add attachments to corrected Claims
- Add attachments to pending Claims
- Easily and quickly void Claims
- Check Claims status
- Receive timely notification of a change in status for a particular Claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

For additional information on EDI Claims submission and Paper Claim Submissions, please refer to the Claims and Compensation section of this Provider Manual.

Electronic Payment Requirement

Participating Providers are strongly encouraged 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 and request that your Tax ID for payer Molina Healthcare of Michigan 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 at 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.

As a reminder, Molina's Payer ID is 38334.

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 (2) 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 HEDIS® needed services (gaps)
- Claims:
    - Submit Professional (CMS1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
    - Correct/Void Claims
    - Add attachments to previously submitted Claims
    - Check Claim 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
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization/Service Requests
    - Check status of Authorization/Service Requests
    - Access prior authorization letters directly through the new Digital Correspondence 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)

Digital Correspondence Hub
The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.

Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not realtime alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

Provider network management portal: enrollment tool

The Provider Network Management Portal is a secure, free tool used to manage Provider enrollment and credentialing requests. All credentialing requests for a Provider to join the network must be submitted electronically through the portal.

Available functions include:
- Adding practitioners to an existing group
- Submitting credentialing requests
- Tracking credentialing and participation status
- Providing additional or missing information for enrollment or credentialing
- Uploading provider rosters
- Adding new facility locations

Access
Office managers, administrative personnel, or Providers who need access to the portal for the first time must submit a registration request directly through the Provider Network Management Portal at Molina/ProviderManagement.

Balance Billing

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 Member for Covered Services is prohibited, except for the Member's applicable copayment, coinsurance, and deductible amounts.

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.

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 representatives 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 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.

Providers who contract with Molina may verify a Member's eligibility by checking the following:

- Availity Essentials portal at provider.MolinaHealthcare.com
- Molina Provider Contact Center automated IVR system at (855) 322-4077

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

Member Cost Share

Providers should verify the Molina Member's cost share status prior to requiring the Member to pay copay, coinsurance, 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).

Health Care Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Molina's Utilization Management and Care Management 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 Health Care Services section of this Provider Manual.

In Office Laboratory Tests

Molina's policies allow 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 on the Molina website at MolinaHealthcare.com under Forms Physician Office Laboratory Tests.

Additional information regarding In-Network Laboratory Providers and In-Network Laboratory Provider patient service centers is found on the laboratory Providers' respective websites at appointment.questdiagnostics.com/patient/confirmation and labcorp.com/labs-and-appointments.

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

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

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of Emergency Services. 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 to 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 Health Care 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.

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 Provider and Members regarding Medically Necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate any and 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 Pharmacy section of this Provider Manual.

Participation in Quality Improvement Programs

Providers are expected to participate in Molina's Quality Improvement (QI) 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 protected health information. 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 Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation, State and Federal requirements. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process.

For additional information about Molina's Credentialing program please 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 Delegated Services Addendum. For additional information on Molina's delegation requirements and delegation oversight please refer to the Delegation section of this Provider Manual.

Primary Care Provider (PCP) 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 Management (i.e. Children's Special Healthcare Services, children and youth in foster care, and health related social needs)
- Participate in the development of Care Management treatment plans

DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Molina. Molina may delegate:

1. Utilization Management
2. Credentialing and Recredentialing
3. Claims
4. Complex Case Management
5. CMS Preclusion List Monitoring
6. 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. Upon satisfactory completion of the initial pre-delegation assessment(s), the proposed delegation is reported to the applicable Delegation Oversight Committee (DOC), or other designated committee. Approval of all delegation, including any sub-delegation arrangements must occur prior to effective date of contract. 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/or 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 Contract Manager.