

PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of California
(Molina Healthcare or Molina)

Molina Marketplace
2024

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

Important Notice: Please be aware that if you are a California resident, you have new privacy rights with respect to the business contact information that you share with Molina as a provider. For more details, please see the “Business Contact Information” section on page 103.

Last Updated: 01/2024



TABLE OF CONTENTS

| | | |
|-----|--------------------------------------------------|-----|
| 1. | MARKETPLACE PRODUCTS | 2 |
| 2. | CONTACT INFORMATION | 3 |
| 3. | PROVIDER RESPONSIBILITIES..... | 9 |
| 4. | CULTURAL COMPETENCY AND LINGUISTIC SERVICES..... | 20 |
| 5. | MEMBER RIGHTS AND RESPONSIBILITIES..... | 26 |
| 6. | ELIGIBILITY AND GRACE PERIOD..... | 27 |
| 7. | BENEFITS AND COVERED SERVICES | 31 |
| 8. | HEALTH CARE SERVICES (HCS)..... | 35 |
| 9. | BEHAVIORAL HEALTH | 57 |
| 10. | QUALITY | 62 |
| 11. | RISK ADJUSTMENT MANAGEMENT PROGRAM | 81 |
| 12. | COMPLIANCE..... | 83 |
| 13. | CLAIMS AND COMPENSATION | 104 |
| 14. | COMPLAINTS, GRIEVANCE AND APPEALS PROCESS | 119 |
| 15. | CREDENTIALING AND RECREDENTIALING..... | 123 |
| 16. | DELEGATION..... | 133 |
| 17. | PHARMACY..... | 140 |

1. MARKETPLACE PRODUCTS

Molina Marketplace Plan Information

Molina offers six (6) levels of affordable health plans for Molina Members:

- Molina \$0 Cost Share HMO AI-AN
- Molina Minimum Coverage HMO
- Molina Bronze
- Molina Silver
- Molina Gold
- Molina Platinum

2. CONTACT INFORMATION

Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

Provider Relations Department

The Provider Relations department oversees telephone and email inquiries from Providers regarding issue resolution, provider education, and training. The department has Provider Relations representatives who serve all of Molina’s Provider network.

| Service County Area | Provider Relations Representative | Contact Number | Email Address |
|-----------------------------------|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| California Hospital Systems | Deletha Foster Teresa Suarez Laura Gonzalez | 909-577-4351 562-549-3782 562-549-4887 | Deletha.Foster@molinahealthcare.com Teresa.Suarez2@molinahealthcare.com Laura.Gonzalez3@molinahealthcare.com |
| Los Angeles | Clemente Arias Christian Diaz Daniel Amirian LaToya Watts Anita White | 562-517-1014 562-549-3550 562-549-4809 562-549-4069 562-980-3947 | Clemente.Arias@molinahealthcare.com Christian.Diaz@molinahealthcare.com Daniel.Amirian@molinahealthcare.com Latoya.Watts@molinahealthcare.com Princess.White@molinahealthcare.com |
| Los Angeles / Orange County | Maria Guimoye | 562-549-4390 | Maria.Guimoye@molinahealthcare.com |
| Sacramento | Johonna Eshalomi Marina Higby | 562-549-3708 916-561-8550 | Johonna.Eshalomi@molinahealthcare.com Marina.Higby@molinahealthcare.com |
| San Bernardino | Luana McIver | 909-501-3314 | Luana.Mciver@molinahealthcare.com |
| San Bernardino / Riverside County | Vanessa Lomeli | 909-577-4355 | Vanessa.Lomeli2@molinahealthcare.com |
| Riverside County | Mimi Howard | 562-549-3532 | Smimi.Howard@molinahealthcare.com |
| San Diego / Imperial County | Briana Givens Salvador Perez Dolores Ramos Lincoln Watkins | 562-549-4403 562-549-3825 562-549-4900 858-300-7722 | Briana.Givens@molinahealthcare.com Salvador.Perez@molinahealthcare.com Dolores.Ramos@molinahealthcare.com Lincoln.Watkins@molinahealthcare.com |

Provider demographic changes, including additions, terminations, and updates should be emailed to the following county mailboxes:

San Diego County: MHCSanDiegoProviderServices@MolinaHealthcare.Com

LA/OC Counties: MHC_LAProviderServices@MolinaHealthcare.Com

Inland Empire County: MHCIProviderServices@MolinaHealthcare.Com

Imperial County: MHCImperialProviderServices@MolinaHealthcare.Com

Sacramento County: MHCSacramentoProviderServices@MolinaHealthcare.Com

Member Services Department

The Member Services department oversees all telephone and written inquiries regarding benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services representatives are available 8 a.m. to 6 p.m., local time, Monday through Friday, excluding State holidays.

Phone: (888) 858-2150

Hearing Impaired: (TTY/TDD) 711

Molina One Stop Help Center

One Stop Help Center is for the community at large to be connected to different resources all at no cost.

Community services could include:

- Enrollment support for Medi-Cal, Covered CA, and Medicare
- Molina Member Services in-person support such as requesting a new member ID card, changing your PCP, etc.
- Utility assistance, rental assistance, and other programs
- Free tax preparation all year round
- CalFresh support and enrollment
- Assistance with Citizenship and the DACA program
- Housing Support
- Support Groups
- Connecting with a Case Manager
- Parents and Children will also be able to obtain free Children's books
- Legal Aid referrals and services

Riverside – Indio

Phone: (855) 665-4621

81735 Hwy 111, Ste. B Indio CA 92201

San Diego

Phone: (855) 665-4621
576 N. 2nd St. El Cajon CA 92021

Claims Department

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

- EDI Payer ID 38333

To verify the status of your claims, please use the [Availity](#) portal. Claims questions can be submitted through the chat feature on the [Availity](#) portal, or by contacting the Provider Contact Center at (855) 322-4075.

Claims Recovery Department

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

| | |
|-----------------------|------------------------------------------------------------------------------|
| Provider Disputes | Molina Healthcare of California PO Box 22722 Long Beach, CA 90802 |
| Refund Checks Lockbox | Molina Healthcare of California PO Box 30567 Los Angeles CA 90030-0567 |
| Phone | (866) 642-8999 |
| Fax | (888) 396-1060 |

Compliance and Fraud AlertLine

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

Compliance Officer
Molina Healthcare of California
200 Oceangate, Suite 100
Long Beach, CA 90802

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

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) 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.

Phone: (888) 562-5442

Fax: (800) 457-5213 and 800-457-5203

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 to assess symptoms and help make good health care decisions.

Telephone: (888) 275-8750

Hearing Impaired: (TTY/TDD) 711 Relay

Health Care Services (UM) Department

The Health Care Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and processes Prior Authorizations/Service Requests. As applicable members may be referred to the Health Care Services (HCS) Case Management department for Members who may 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 options:

- Submit requests directly to Molina via the [Availity](#) portal.

- Submit requests via 278 transactions. See the EDI transaction section of Molina’s website for guidance.

Health Care Services Authorizations & Inpatient Census

Availability: provider.MolinaHealthcare.com

Prior Authorization Phone: (844) 557-8434

Prior Authorization Fax: (800) 811-4804

Inpatient Phone: (866) 814-2221

Inpatient Fax: (866) 553-9623

Health Management

Molina provides Health Management Programs designed to assist Members and their families in better understanding their chronic health condition(s) and adopting healthy lifestyle behaviors.

Molina’s Health Management programs will be incorporated into the Member’s treatment plan to address the Member’s health care needs.

Phone: (833) 269-7830

Fax: (800) 642-3691

Behavioral Health

Molina manages all components of covered services for behavioral health. For Member behavioral health needs, please contact us directly at (888) 275-8750. Molina has a Behavioral 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.

Pharmacy Department

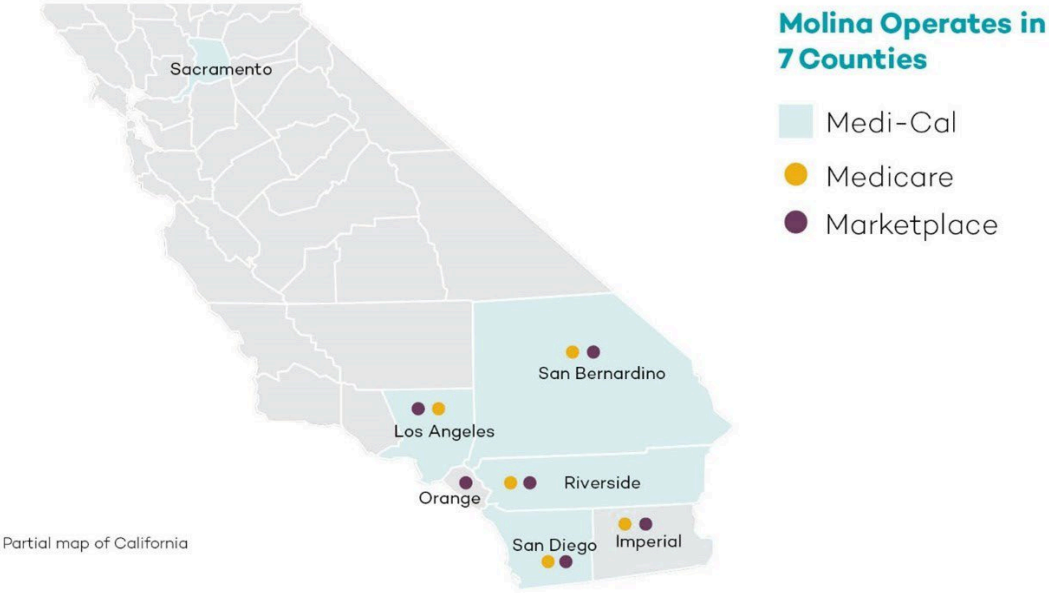
Prescription drugs are covered by Molina through the CVS Caremark Pharmacy Network. A list of in-network pharmacies is available on the MolinaMarketplace.com website, or by contacting Molina at (855) 322-4075.

Quality

Molina maintains a Quality Improvement department to collaborate with Members and Providers in administering Molina’s Quality Programs.

Phone: (800) 526-8196, Ext. 126137

Molina Healthcare of California Service Area



3. PROVIDER RESPONSIBILITIES

Nondiscrimination in Health Care Service Delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic 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

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

Facilities, Equipment and Personnel

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).

Supporting Effective Care Transitions

Acute care facilities, long-term acute care hospitals, and skilled nursing facilities are required to establish policies and procedures to support effective care transitions. This includes written protocols for discharge planning. Facilities are expected to notify and communicate with primary care providers and to coordinate continuity of care with prior PCP and ECM providers, including sharing of discharge summaries, care plans, and medication lists.

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.

Providers must validate their Provider information on file with Molina at least once every ninety (90) days for correctness and completeness.

Failure to do so may result in your REMOVAL from the Marketplace Provider directory and Provider network. Provider information that must be validated includes, but is not limited to:

- Provider or practice name
- Location(s)/Address
- Specialty(ies)
- Telephone number, fax number, and email
- Digital contact information
- Whether your practice is open to new patients (PCPs only)
- Tax ID and/or National Provider Identifier (NPI)
- Provider Network Affiliation

The information above must be provided as follows:

Delegated Providers, and other Providers that typically submit rosters, must submit a full roster that includes the above information to Molina at:

- MHCIEProviderServices@MolinaHealthcare.com
- MHCSacramentoProviderServices@MolinaHealthcare.com
- MHCImperialProviderServices@MolinaHealthcare.com
- MHCSanDiegoProviderServices@MolinaHealthcare.com
- MHCLAProviderServices@MolinaHealthcare.com

All other Providers must log into your CAQH account to attest to the accuracy of the above information for each health care Provider and/or facility in your practice that is contracted with Molina. If the information is correct, please select the option to attest that the information is correct. If the information is not correct, Providers can make updates through the [CAQH portal](#). Providers unable to make updates through the [CAQH portal](#) should contact their Provider Relations representative for assistance.

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 our membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

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 Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of the [Availity](#) portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and claims submitted through the [Availity](#) portal.

Any Provider entering the network as a Contracted Provider will be encouraged to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the [Availity](#) 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 [MolinaMarketplace.com](#).

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- [Availity](#) portal

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](#) portal
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38333, refer to our website [MolinaMarketplace.com](#) for additional information

While both options are embraced by Molina, submitting Claims via the [Availity](#) 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](#) portal Claims submission includes the ability to:

- Add attachments to Claims
- Submit corrected 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, please refer to the Claims and Compensation section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

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

Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/ACH, a physical check, or a virtual card.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO.

You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested.

If you would like to opt-out of receiving a Virtual Card prior to your first payment, you may contact ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of California 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 38333.

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 MolinaMarketplace.com.

Availity

Providers and third-party billers can use the no cost [Availity](#) 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.
 - Correct/Void Claims.
 - Add attachments to previously submitted Claims.
 - Check Claims status.
 - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
 - Create and manage Claim Templates.
 - Create and submit a Claim Appeal with attached files.
- Prior Authorizations/Service Requests.
 - Create and submit Prior Authorization/Service Requests.
 - Check status of Authorization/Service Requests.
- Download forms and documents.
- Send/receive secure messages to/from Molina.

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 or Evidence of Coverage).

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 representative 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 service.

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

- Availability at provider.MolinaHealthcare.com
- Molina Provider Contact Center automated IVR system at (855) 322-4075

For additional information please refer to the Eligibility and Grace Period 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, or Deductible that may be applicable to the Member's specific benefit plan. After the Member reaches the Annual Out-of-Pocket Maximum, they are no longer responsible for further charges for the remainder of that policy 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: [MolinaMarketplace.com](https://www.molinahealthcare.com/Marketplace).

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 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 who 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 can refer a Member to an in-network specialist for consultation and treatment; prior authorization may be required depending on delegation.

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 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.

Maternal Mental Health Screening

AB 2193 Maternal Mental Health requires a licensed health care Practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. A health Provider must use a validated tool to assess the Member's mental health, either in the prenatal or postpartum period, or both. Two examples are the [Patient Health Questionnaire-9 \(PHQ-9\)](#) and the [Edinburgh Postnatal Depression Scale \(EPDS\)](#). Molina requires health care Providers to document mental health screening for pregnant or postpartum Members using the current CPT/HCPCS claim codes. Molina Maternal Mental Health Program guidelines and criteria are available upon request by contacting the Provider Contact Center.

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 Programs

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

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

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

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member 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 ten (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 Complaints, Grievance and Appeals Process 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 on Molina's Credentialing program, including Policies and Procedures, 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, applicable laws, regulations, and accreditation standards. For additional information on Molina's delegation requirements and delegation oversight, please refer to the Delegation section of this Provider Manual.

Primary Care Provider Responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members.

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

4. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with 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, blind, have low-vision, are 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 colors, creeds, health statuses, marital status, ancestry, language, gender identities, sexual orientations, ages, and religions as well as those with disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at [MolinaMarketplace.com](https://www.molinahealthcare.com/marketplace), from your local Provider Relations representative, and by calling the Molina Provider Contact Center at (855) 322-4075.

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 of the need for 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 Member Agreement and Combined Evidence of Coverage and Disclosure Form located at <https://www.molinahealthcare.com/marketplace/ca/es-us/Notice-of-Nondiscrimination.aspx>

3. You **MUST** post in a conspicuous location in your office, a Tagline Document, which explains how to access non-English language services. A sample of the Tagline Document that you will post can be found in Member Agreement and Combined Evidence of Coverage and Disclosure Form located at <https://www.molinamarketplace.com/marketplace/ca/en-us/MemberForms.aspx>.
4. If a Molina Member needs 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”). Molina provides language assistance services that are free of charge, accurate, and timely, and that protect the privacy and independence of limited English proficient (LEP) members. You can find resources for accessing interpreter services at <https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ca/MediCal/cultural-and-linguistic-services>. Resources on meeting your LEP obligations can be found at <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html>. See also, <https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html>.
5. If a Molina Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Molina’s Civil Rights Coordinator or the HHS-OCR:

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

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

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful, culturally competent service delivery. Molina integrates cultural competency training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances how

people think about our members, service delivery, and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff, and Community-Based Organizations. Molina conducts Provider training during Provider orientation, plus annual reinforcement training offered through Provider Relations and/or with online/web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials
2. On-site cultural competency training
3. Online cultural competency Provider training modules and videos. These can be found on Molina's website here: <https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/Health-Resources/Culturally-and-Linguistically-Appropriate-Resources-Disability-Resources>
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

Molina ensures Members access to language services such as oral interpretation, American Sign Language (ASL), and written translation. Molina must also ensure access to programs, aids, and services congruent with cultural norms. Molina supports Members with disabilities and assists Members with limited English proficiency (LEP) to provide meaningful access to interpretation services when needed. Based on the needs of the member, Molina may deliver interpretation in person, via video remote interpretation (VRI), or over the phone

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, electronic files), leading to better communication, understanding, and Member satisfaction. Online materials found at <https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/Health-Resources/Health-Management> 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 Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Member Contact Center toll free at (888) 858-2150. The Contact Center

representative will immediately connect you and the Member to a qualified language service Provider.

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

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

An LEP individual has a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations).

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 collaborate with individuals with cognitive impairments.
- Be notified by the medical Provider that interpreter services are available at no cost.
- 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 native language, assist with a disability, or help the Member understand the information.

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

- Verify the Member's eligibility and medical benefits.
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available.
- Molina is available to assist Providers with locating these services if needed:
 - Providers needing assistance finding onsite interpreter services.
 - Providers needing assistance finding translation services.
 - Providers with Members who cannot hear or have limited hearing ability may use TTY/TDD at 711.
 - Providers with Members with limited vision may contact Molina for documents in large print, Braille, or audio version.

Providers with Members with limited reading proficiency (LRP). The Molina Member Services representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Molina offers Video Remote Interpretation (VRI) if a telephonic interpreter will not provide meaningful access for an appointment. VRI can be accessed through any standard smartphone, tablet, or laptop. No specific software is needed, and the platform is HIPAA compliant and can be used for telehealth visits as well as in-person appointments. VRI appointments can be requested by calling the Contact Center at least forty-eight (48) hours in advance of an appointment.

Molina offers qualified onsite interpreter services to Providers and Members at medical appointments based on complex medical cases. Providers and Members may call Molina's Contact Center to submit a request. Requests should be made at least three (3) business days in advance of an appointment.

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. 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 Member & Provider Contact Center, Quality, Health Care Services, and all other health plan functions.

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

Molina provides video remote interpreter and face-to-face service delivery for ASL to support our members who are deaf or hard of hearing either via Video Remote Interpretation (VRI) or an onsite interpreter. Requests should be made through Molina's Contact Center 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 Molina Member Services.

Nurse Advice Line

Molina provides Nurse Advice services for Members 24 hours per day, 7 days per week. The Nurse Advice Line provides access to 24-hour interpretive services. Members may call Molina's Nurse Advice Line directly at (888) 275-8750 or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership 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.
- Collection of data and reporting for the Diversity 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 within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan (QHP) Enrollee Experience survey results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

5. MEMBER RIGHTS AND RESPONSIBILITIES

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

State and Federal Law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Molina at (888) 858-2150, 8 a.m. to 6 p.m., local time, Monday through Friday. TTY/TDD users, please call 711.

Second Opinions

If a Member does not agree with their Provider's plan of care, they have the right to request a second opinion from another Provider. Members should call Member Services to find out how to get a second opinion. Second opinions may require Prior Authorization.

6. ELIGIBILITY AND GRACE PERIOD

Eligibility Verification

Health Insurance Marketplace Programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Eligibility Listing for Molina Marketplace Programs

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

- Availability at provider.MolinaHealthcare.com
- Molina Provider Contact Center automated IVR system at (855) 322-4075
- Covered California

Possession of a Molina ID Card does not mean a recipient is eligible for Marketplace services. A Provider should verify a recipient's eligibility each time the recipient presents to their office for services. The verification sources can be used to verify a recipient's enrollment in a Molina Marketplace plan.

Identification Cards

Molina Sample Member ID Card



The image shows a sample Molina Member ID Card. The card has a teal header with the Molina Healthcare logo and the word "Marketplace" in a purple box. Below the header, there are fields for Subscriber information (Subscriber, Subscriber ID, Plan) and Member information (Member, Member ID, Effective Date). There are also sections for Cost Share (PCP, Specialist, Urgent Care, ER Visit, Pref. Generic Rx, Pref. Brand Rx) and Deductibles (Medical Indv Deductible, RX Indv Deductible, Annual Out of Pocket Maximum (OOPM), Indv OOPM). The card includes contact information for Member Numbers, Provider Numbers, and Medical Claims. It also features the CVS Caremark logo and a notice that the card is for identification purposes only.

Member Numbers
Member Services: (888) 858-2150
TTY/TTD: 711
24/7 Nurse Advice: (888) 275-8750
24/7 Linea de Consejos de Enfermeras:
(866) 648-3537
Billing and Payments:
(800) 772-5327
Pediatric Dental Member Services:
(855) 230-5530
Cost Shares are a summary only.
Visit MyMolina.com for plan details.
Notice: Covered Services must be received from Participating Providers. Refer to your Agreement for exceptions.
MyMolina.com This card is for identification purposes only and does not prove eligibility for service.

Provider Numbers
CVS Caremark Help desk: (888) 407-6425
Prior Authorization/Notification of Hospital Admission: (855) 322-4075
Medical Claims:
Molina Healthcare
PO BOX 22702
Long Beach, CA 90801
Inpatient Admissions: Provider to notify plan within 24 hours of admission.

Subscriber:
Subscriber ID:
Plan:

Member:
Member ID:
Effective Date:

Cost Share
PCP:
Specialist:
Urgent Care:
ER Visit:
Pref. Generic Rx
Pref. Brand Rx:

Deductibles
Medical Indv Deductible:
RX Indv Deductible:
Annual Out of Pocket Maximum (OOPM)
Indv OOPM:

RxSIN: RxPCN: RxGRP:
HMO Molina Healthcare of California

CVS caremark

Members are reminded in their agreement to present ID cards when requesting medical or pharmacy services. The Molina ID card can be a physical ID card or a digital ID card. 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.

Grace Period

Definitions

APTC Member: A Member who receives (federal) advanced premium tax credits (premium subsidy), which helps to offset the cost of monthly premiums for the Member.

APA Member: A Member who receives Advanced Premium Assistance from the state which helps to offset the cost of monthly premiums for the Member.

Non-Subsidy Member: A Member who is not receiving any advanced premium tax credits or advanced premium assistance from the state and is therefore solely responsible for the payment of the full monthly premium amount.

Member: An individual, including any dependents, enrolled in Molina Marketplace. This term includes APTC Members, APA Members, and Non-Subsidy Members.

Summary

The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with state law to 1) APA Members for three (3) consecutive months; and to 2) Non-Subsidy Members, for a period of thirty (30) days, who fail to pay their monthly premium by the due date.

To qualify for a grace period, the Member must have paid at least one (1) full month's premium within the benefit year. The grace period begins on the first day of the first month for which the Member's premium has not been paid. The grace period is not a "rolling" period. Once the Member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace Period Timing

Non-Subsidy Members

Non-Subsidy Members are granted a thirty (30)-day grace period, during which they may be able to access all services covered under their benefit plan. If the *full past-due premium* is not paid by the end of the grace period, the Non-Subsidy Member will be terminated as of the first day following the last month for which the premium was paid.

APTC and APA Members

Both APTC and APA Members are granted a three (3)-month grace period. During the first month of the grace period Claims, including Pharmacy Claims, and authorizations will continue to be processed. During the second and third months of the grace period, the Member's coverage will be suspended, and Claims and authorization will not be processed. If the Member's *full past-due premium* is not paid by the end of the third month of the grace period, the Member will be retroactively terminated as of the last day of the first month of the grace period.

Service Alerts

When a Member is in the grace period, Molina will include a service alert on the [Availity](#) portal, interactive voice response (IVR) and in the call centers. This alert will provide detailed information about the Member's grace period status, including which month of the grace period that the Member is in (first month vs. second and third) as well as information about how authorizations and Claims will be processed during this time. Providers should verify both the eligibility status AND any service alerts when checking a Member's eligibility. For additional information about how authorizations and Claims will be processed during this time, please refer to the Member's Evidence of Coverage, or contact Molina's Provider Contact Center at (855) 322-4075.

Notification

All Members will be notified upon entering the grace period. Additionally, when either an APTC or APA Member enters the grace period, their eligibility becomes available on the [Availity](#) portal and should be checked prior to providing services. Additionally, Molina will notify Providers as follows:

- Members who receive APTC and have entered the first month of the grace period will not have any service restrictions. Therefore, the message that Providers will see upon checking the [Availity](#) portal will read as follows: "No Enrollment Restrictions."
- The APTC/APA Member's assigned PCP, medical group, any provider with an outstanding authorization and any Provider who submitted claims for the Member in the two (2) months prior to the start of the grace period will receive a "Notice of Suspension" stating that the Member has entered the three (3)-month grace period.
- Providers who submit Claims for services rendered during the grace period will receive notification that the APTC/APA Member is in the grace period.

This notification will advise Providers that services rendered during the second and third months of the grace period may be denied if the premium is not paid in full prior to the expiration of the third month of the grace period.

Prior Authorizations

All authorization requests will be reviewed based on Medical Necessity and will expire after ninety (90) days. If a request for a prior authorization is made, the Provider will receive the

following disclaimer: “Prior Authorization is a review of medical necessity and is not a guarantee of payment for services. Payment will be made in accordance with a determination of the Member’s eligibility on the date of service (for Molina Marketplace Members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable Provider agreement.”

Molina will delay claims for services provided to APTC/APA Members in months two (2) and three (3) of the federally or state required three (3)-month grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional information on a Marketplace Member’s grace period status, please contact Molina.

APTC and APA Members

All authorization requests will be reviewed based on Medical Necessity.

Non-Subsidy Members

Authorization requests received during a Non-Subsidy Member’s thirty (30)-day grace period will be processed according to Medical Necessity standards.

Claims Processing

APTC and APA Members

First Month of Grace Period: Clean Claims received for services rendered during the first month of a three (3)-month grace period will be processed using Molina’s standard processes and in accordance with state and federal statutes and regulations and within established turn-around-times.

Second/Third Month of Grace Period: Clean Claims received for services rendered during the second and third months of an APTC/APA Member’s three (3)-month grace period will be pending until the premium is paid in full. In the event that the Member is terminated for non-payment of the *full premium* prior to the end of the grace period, Molina will deny Claims for services rendered in the second and third months of the grace period. Pharmacy Claims will be processed based on program drug utilization review and formulary edits; the Member will be charged 100 percent of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-Subsidy Members

Clean Claims received for services rendered during the thirty (30)-day grace period will be processed using Molina’s standard processes and in accordance with state and federal statutes and regulations and within established turn-around-times.

7. BENEFITS AND COVERED SERVICES

Molina covers the services described in the Summary of Benefits and Coverage and in the Schedule of Benefits section of the Member Evidence of Coverage (EOC) document for each Molina Marketplace plan. If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located on the MolinaMarketplace.com/CAGetCare website and [Availity](#) portal. You may also contact Molina at (855) 322-4075.

Verification of Benefits

Detailed information about benefits and services can be found in the Schedule of Benefits section of the EOC document made available to Molina Marketplace Members via the Molina Member Portal and on the Molina public website. Providers can access benefit details via the [Availity](#) portal.

Member Cost Share

Cost Share is the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services provided under their Molina Marketplace plan. The Cost Share Amount Members will be required to pay for each type of Covered Service is summarized on the Member's ID card. Additional detail regarding Cost Share is listed in the Schedule of Benefits. Cost Share applies to all Covered Services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). Cost Share towards Essential Health Benefits may be reduced or eliminated for certain eligible Members, as determined by Marketplace's rules.

A Member pays the lesser of the cost share amount or billed charges.

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

Non-Formulary Drug Exception Request Process

There are two (2) types of requests for Formulary exception:

- "Expedited Exception Request" for urgent circumstances that may seriously jeopardize life, health, or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- "Standard Exception Request."

The Member and/or Member's representative and the prescribing Provider will be notified of Molina's decision no later than:

- 24 hours following receipt of request for Expedited Exception Request.

- 72 hours following receipt of request for Standard Exception Request.

If the initial request is denied, an external review may be requested. The Member and/or Member's representative and the prescribing Provider will be notified of the external review decision no later than:

- 24 hours following receipt of the request for external review of the Expedited Exception Request.
- 72 hours following receipt of the request for external review of the Standard Exception Request.

Injectable and Infusion Services

Many self-administered and office-administered injectable products require Prior Authorization (PA). In some cases, they will be made available through a vendor designated by Molina. More information about our Prior Authorization process, including a link to the PA request form, is available in the Pharmacy section of this Provider Manual.

Family planning services related to the injection or insertion of a contraceptive drug or device are covered.

Emergency Mental Health or Substance Use Disorder

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

- Danger to harm yourself or someone else.
- A mental health crisis, a substance use crisis, or any other kind of emotional distress likely to 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 emergency room.
- Call the number on ID card.
- Call Member's PCP and follow-up within twenty-four (24) to forty-eight (48) hours.

For out-of-area Emergency care, 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 the use of special equipment, life support systems, and close monitoring by trained attendants while in route to the nearest appropriate facility, emergency transportation is thus required and covered. Emergency transportation includes, but is not limited to, ambulance, air, or boat transports.

For emergency ground and air ambulance, for both in-network and out-of-network providers, the member is responsible only for the plan's in-network cost-sharing amount, and providers are prohibited by state and federal law from balance billing the member.

Preventive Care

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

MolinaHealthcare.com/providers/ca/medicaid/resource/Pages/guide_prevent.aspx.

Nurse Advice Line

Members may call the Nurse Advice Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week, to assess symptoms and help make good health care decisions.

Molina is committed to helping our Members:

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

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

Telehealth and Telemedicine Services

Molina Members may obtain physical and behavioral 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 Telehealth services from Participating Providers, who offer and have the capability of providing these services with associated plan cost share.
- 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.
- Member cost sharing may apply based on the applicable Schedule of Benefits.
- 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.
- A licensed physician and/or surgeon in another state would be authorized to deliver health care via telehealth to eligible members whom, among other requirements, has an immediately life-threatening disease or condition, in accordance with the David Hall Act Assembly Bill 1369.

If a Member is currently receiving specialty telehealth services for mental health or behavioral health condition, the Member is given the option of continuing to receive those services with the contracting individual health professional, a contracting clinic, or contracting health facility.

Ensure records are entered into a patient record system shared with the Member's primary care Provider or are otherwise provided to the Member's primary care Provider, unless the Member objects, in a manner consistent with the state and federal law.

Third-party "corporate telehealth provider" means a corporation directly contracted with a health care service plan that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

Third party corporate telehealth Providers are to obtain enrollee consent to receive the service via telehealth through a third-party corporate telehealth Provider consistent with Business and Professions Code Section 2290.5.

Third party corporate telehealth Providers are required to submit reporting data as requested and specified by Molina.

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

8. HEALTH CARE SERVICES (HCS)

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Molina provides care management 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 utilization management program include pre-service authorization review, inpatient authorization management that includes 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 the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- 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 processes.
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decision.

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 an UM reviewer, access Molina’s 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 decision 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 or payment of request (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.

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 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 (844) 557-8434 to obtain Molina's UM Criteria.

Where applicable, Molina Corporate Policies can be found on the public website at [MolinaClinicalPolicy.com](https://www.molinahealthcare.com/clinical-policy). Please note that Molina follows state-specific criteria, if available, before applying Molina-specific criteria.

Medical Necessity

“Medically Necessary” or “Medical Necessity” means:

- For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

This is for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. Molina must deem those services to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury, or disease; and,
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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 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, a medical necessity 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 [Avality](#) 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 all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the [Avality](#) portal and is available 24 hours per day, 7 days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available. 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 LookUp Tool at [MolinaMarketplace.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, Molina clinical policies, and 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 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 allows 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 Molina Hospital or Provider Relations Agreement. 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 <https://www.molinamarketplace.com/marketplace/ca/en-us/Providers/Provider-Forms>.

Providers are encouraged to use the Molina prior authorization form provided on the Molina website. 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 (NMPHA).

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. The definition of expedited/urgent is when the 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 medical health condition or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request, or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

Molina will make an 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 (844) 557-8434 during business hours.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax, or via the [Availity](#) portal. If a request is denied, the requestor and the Member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider via fax.

Peer-to-Peer Review

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

A “peer” is considered a physician, physician assistant, or nurse practitioner who is directly providing care to the Member or is well familiarized with the care being provided to the Member.

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

- Member name and ID #
- Auth ID #
- Requesting Provider Name and contact number, 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.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement 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 MolinaMarketplace.com website:

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

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

Availity Portal: Participating Providers are encouraged to use the [Availity](#) portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the [Availity](#) portal. The benefits of submitting your prior authorization request through the [Availity](#) portal are:

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

Fax: The Prior Authorization Request Form can be faxed to Molina at (800) 811-4804.

Phone: Prior authorizations can be initiated by contacting Molina’s Healthcare Services department at (844) 557-8434. It may be necessary to submit additional documentation before the authorization can be processed.

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 function 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 and 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 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 (844) 557-8434 during normal business hours, Monday through Friday (except for Holidays) from 8:30 a.m. to 5:30 p.m. All staff Members identify themselves by providing their first name, job title, and organization.

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

After business hours, Providers can also utilize fax and the [Availity](#) portal for UM access.

Molina’s Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (888) 275-8750 (English), (866) 648-3537 (Spanish). Molina’s Nurse Advice Line may manage urgent and emergent after-hours UM calls.

Emergency Services

Emergency Services means: Those services needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition or Emergency means: a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to 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 twenty-four (24)-hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Molina also provides Members a twenty-four (24)-hour Nurse Advice line for medical advice. In addition, the 911 information is 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 twenty-four (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 an available participating facility. Services provided after stabilization in a non-participating facility are not covered and the Member may be responsible for payment. Member payments to the non-participating facility will not apply to the Member's deductible or annual out-of-pocket maximum.

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

Case 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.

Emergency Department Support Unit (EDSU)

Molina highly encourages that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. While the Member is in the Emergency Room, call (844) 9-Molina or (844) 966-5462.

Additionally, **clinical records for authorization of post-stabilization care can be faxed to the dedicated EDSU fax number (877) Molina 5 or (877) 665-4625.** This fax number is used exclusively for Members currently in the ER, to help expedite requests and assist with discharge planning.

Molina's Emergency Department Support Unit (EDSU) will collaborate with the ER to provide assistance to ensure Members receive the care they need when they need it.

The EDSU is a dedicated team, available 24 hours a day, 7 days a week to provide support by:

- Assisting in determining appropriate level of placement using established clinical guidelines.
- Issuing authorizations for post-stabilization care, transportation, or home health.
- Involving an On-Call Medical Director for any Peer-to-Peer reviews needed.
- Working with pharmacy to coordinate medications or infusions as needed.
- Obtaining SNF placement if clinically indicated.
- Coordinating placement into Case Management with Molina when appropriate.
- Beginning the process of discharge planning and next day follow-up with a Primary Care Provider if indicated.

Notification Requirements:

When a member receives stabilization services in the hospital Emergency Room, Molina requires timely notification to the EDSU for any post stabilization services, i.e., inpatient admission.

Molina strongly recommends that requests for authorization of post-stabilization services be communicated telephonically via the EDSU. Contact with the EDSU will be considered a formal request that requires a determination for post stabilization services and will be responded to within thirty (30) minutes.

For EDSU, **please call:** (844) 9-Molina or (844) 966-5462

Fax clinical documentation to: (877) Molina 5 or (877) 665-4625

If there is insufficient clinical information to render an approval during the post stabilization timeframe, the EDSU nurse will contact the Molina physician on call for consultation. If the physician determines that clinical information does not support medical necessity, a denial will be issued. Denials may be overturned if additional clinical information is provided to support medical necessity for the admission.

If the request for post stabilization services at a non-par hospital is denied, the EDSU staff will work with the hospital to arrange transfer of the Member to a Molina contracted facility. In addition, if the request for post stabilization services is for a higher level of care, the hospital will initiate transfer with the EDSU. The EDSU staff will work with the hospital to assist in the

transfer of the Member to a facility that is able to provide the level of care needed by the Member.

For post stabilization services that are denied, the hospital may submit Claims for observation level of care for payment consideration.

Notifications received from hospitals, where a post-stabilization admission determination is **NOT** expected by the hospital within thirty (30) minutes, will follow the standard Molina UM process.

After hours, weekends and holidays, please call: (844) 9-Molina or (844) 966-5462.

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 an 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 twenty-four (24) hours of admission or by the following business day. 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 inpatient admission may result in a denial of authorization for the inpatient stay.

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 the discharge, unless Law or federal program requirements mandate otherwise.

Inpatient/Concurrent Review

Molina performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. 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. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request.

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

Molina will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. 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 collected 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 our 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.

Molina will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

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

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

- 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.
 - Behavioral 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, 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 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.

Except for Emergency Services and out-of-area Urgent Care Services, Marketplace Members must receive Covered Services from Participating Providers; otherwise, the services are not covered. Exceptions may be made if a required service cannot be provided by an in-network provider, in which case, a Letter of Agreement will be executed. Marketplace Members will be 100 percent responsible for payment and the payments will not apply to towards Deductibles or Annual Out-of-Pocket Maximums.

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 collaborate 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, caregiver, or Provider referrals. 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 addressing 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 of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member 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 (888) 665-4621.

Continuity and Coordination of Provider Communication

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

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age, or illness; and who is, or may be unable to take care of themselves, or unable to protect themselves against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or 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

Department of Social Services: cdss.ca.gov/reporting/report-abuse/child-protective-services/report-child-abuse

Imperial County

(760) 337-7750

Los Angeles County

(800) 540-4000 – Within CA

(213) 639-4500 – Outside CA

(800) 272-6699 – TDD

Online Reporting: <https://mandreptla.org/cars.web/>

Riverside County

(800) 442-4918

(877) 922-4453

Sacramento County

(916) 875-5437

San Bernardino County

(909) 384-9233

(800) 827-8724

San Diego County

(858) 560-2191

(800) 344-6000

Adult Abuse

Imperial County

Adult Protective Services

Phone: (760) 337-7878

<https://da.imperialcounty.org/programs/#elder>

Los Angeles County

24-Hour Abuse Hotline: (877) 477-3646

General Information, toll free in LA & Vicinity: (888) 202-4248

APS Mandated Reporter Hotline: (877) 477-3646 or (877) 4-R-Seniors - M-F, 8:30 a.m. – 5 p.m.

wdacs.lacounty.gov/programs/aps/

Riverside County

DPSS – Adult Services Central Intake Center

4060 County Circle Drive
Riverside, CA 92501
Hotline: (800) 491-7123
Fax: (951) 358-3969
<https://rivcodpss.org/adult-services>

Sacramento County

Department of Health & Human Services
3701 Branch Center Road
Sacramento, CA 95827
Hotline: (916) 875-5437
Fax: (916) 854-9341
dcfas.saccounty.net/SAS/Pages/Adult-Protective-Services/SP-Adult-Protective-Services.aspx

San Diego County

Adult Protective Services
Hotline: (800) 339-4661
sandiegocounty.gov/content/sdc/hhsa/programs/ais/adult_protective_services.html

San Bernardino County

24-Hour Toll-Free Hotline: (877) 565-2020
hss.sbcounty.gov/daas/programs/APS.aspx

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. The PCP/Medical Group/IPA, other delegated entities, or other clinical personnel take final actions. 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 Utilization Management 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.

Case Manager Responsibilities

The case manager collaborates with the Member and any additional participants as directed by Member to develop an ICP that includes recommended interventions from the 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 case manager, and the Member are responsible for implementing the plan of care. Additionally, the case manager:

- Assess the Member to determine if the Member's needs warrant care management.
- Monitors and communicates the progress of the implemented ICP to the Member's ICT, as Member 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 ICP 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 sixty (60) 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. Members can request to be enrolled or dis-enrolled in these programs at any time. Our Molina My Health programs include:

Health Conditions Management Programs

- Asthma
- Diabetes
- High Blood Pressure
- Heart Failure
- COPD
- Depression

Healthy Lifestyle Programs

- Weight Management
- Tobacco Cessation
- Nutrition

For more information about these programs, please call (833) 269-7830 or (TTY/TDD at 711 Relay) or fax (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 (6th) 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 Form (available at: MolinaMarketplace.com) within fourteen (14) days of pregnancy diagnosis. The form should be faxed to Molina's HEDIS department at (855) 556-1424 or emailed to MHCHEDISPPC@MolinaHealthcare.com.

Diabetes Prevention Program

Molina is in the process of contracting with a new Diabetes Prevention Program vendor. Please contact Health Education at HealthEducation.MHC@MolinaHealthcare.com to find out how to refer a member.

Member Newsletters

Member Newsletters are posted on the MolinaMarketplace.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 evidence-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 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 & Provider 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, prior authorization may be required depending on delegation. 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 case managers may be licensed professionals and are educated, trained, and experienced in the 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 case manager will assess the Member upon engagement after identification for 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 case manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of 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 case 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 resources when identified. The referral source should be prepared to provide the case 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 infants
- High-technology home care requiring more than two (2) weeks of treatment
- Member accessing Emergency Department services inappropriately
- Children with special health care needs

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

Phone: (833) 234-1258

Fax: (562) 499-6105

9. BEHAVIORAL HEALTH

Overview

Molina provides a Behavioral Health benefit for Members. Molina takes an integrated, collaborative approach to behavioral health care, encouraging participation from PCPs, behavioral health, and other specialty Providers to ensure whole person care. Molina complies with the most current Mental Health Parity and Addiction Equity Act requirements. All provisions within the Provider Manual are applicable to medical and behavioral health Providers unless otherwise noted in this section.

Utilization Management and Prior Authorization

Behavioral Health inpatient and residential services for Marketplace Members can be requested by submitting a Prior Authorization Request form or contacting Molina's Prior Authorization team at (844) 557-8434 and fax at (800) 811-4808. Providers requesting after-hours authorization for these services should utilize [Avality](#) portal or fax submission options. Emergency psychiatric services do not require Prior Authorization. All requests for Behavioral Health services should include the most current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted nonprofit professional association criteria for Prior Authorization reviews. For additional information, please see the Prior Authorization subsection found in the Health Care Services section of this Provider Manual.

Access to Behavioral Health Providers and PCPs

Members may be linked with an in-network Behavioral Health Provider via referral from a PCP or by Member self-referral. PCPs are able to screen, assess, and provide referrals for any known or suspected Substance Use or Behavioral Health problem or disorder. PCPs may provide any clinically appropriate Behavioral Health service within the scope of their practice. A formal referral form or Prior Authorization is not needed for a Member to access an in-network PCP, Psychiatrist, psychiatric prescriber, or psychotherapy Behavioral Health Provider.

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

Care Coordination and Continuity of Care

Discharge Planning

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

Interdisciplinary Care Coordination

In order to provide care for the whole person, Molina emphasizes the importance of collaboration among all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care among each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Molina's Care Management program may assist in coordinating care and communication among all Providers of a Member's treatment team.

Care Management

Molina's Care Management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs. Members with high-risk psychiatric, medical, or psychosocial needs, may be referred by a Behavioral Health or Primary Care Provider to the ICM program.

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

Phone: (833) 234-1258

Fax: (562) 499-6105

Additional information on the ICM program can be found in the Care Management subsection found in the Health Care Services section of this Provider Manual.

Responsibilities of Behavioral Health Providers

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

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

appointment timeframes. Please see 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 behavioral health appointment, the Behavioral Health Provider shall contact the Member within twenty-four (24) hours of a missed appointment to reschedule.

Behavioral Health Crisis Line

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

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried 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 primary care and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the MolinaMarketplace.com Provider website.

Behavioral Health Treatment

Behavioral Health Treatment (BHT) Services

Behavioral Health Treatment (BHT) services constitute a comprehensive and evidence-based approach to address behavioral conditions, with a primary focus on promoting the optimal functioning of beneficiaries. These services are designed to prevent or minimize adverse effects of behaviors that may interfere with learning and social interaction, fostering a positive and supportive environment for individuals receiving care.

Key Components of BHT Services:

1. **Applied Behavior Analysis (ABA):** A core component of BHT services, ABA involves the systematic application of behavioral principles to modify socially significant behaviors. It is widely recognized as an effective intervention for individuals with Autism Spectrum Disorder (ASD) and is utilized to target specific behaviors, improve communication skills, and enhance overall adaptive functioning.
2. **Evidence-Based Behavioral Interventions:** BHT services encompass a variety of evidence-based behavioral interventions beyond ABA. These interventions are carefully selected based on their proven efficacy in addressing behavioral challenges and promoting positive outcomes for individuals under care.

Eligibility Criteria:

To receive BHT services under the Medi-Cal program, individuals must meet the following eligibility criteria:

- Be under 21 years of age (for those with an ASD diagnosis, based on the recommendation of a licensed physician and surgeon or a licensed psychologist).
- Meet medical necessity criteria, as determined by a licensed physician and surgeon or a licensed psychologist.

BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. The behavioral treatment plan may be modified if medically necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

Who can provide services

| Definition (Provider) | Billing Modifier | QAS Level |
|-------------------------------------------------|------------------|-----------------|
| Licensed Clinician (MD, Ph.D., LCSW) | AH | Provider (QASP) |
| Doctoral Level Certified Provider (BCBA-D) | HP | Provider (QASP) |
| Master's Degree Level Certified Provider (BCBA) | HO | Provider (QASP) |

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------------|
| <p>Bachelor’s Degree Level Certified Provider (BCaBA) or bachelor’s level qualified professional. Psychological associates, associate marriage and family therapists, associate clinical social workers, or associate professional clinical counselors, as defined, and regulated by the Board of Behavioral Sciences or the Board of Psychology. Requires that qualified autism service professionals who are psychological associates, associate marriage and family therapists, associate clinical social workers, or associate professional clinical counselors will also meet the criteria set forth in the regulations adopted pursuant to Welfare & Institutions Code § 4686.4 for a Behavioral Health Professional.</p> | <p>HN</p> | <p>Professional (QASPRO)</p> |
| <p>Unlicensed or uncertified Provider</p> | <p>HM</p> | <p>Paraprofessional (QASPARA)</p> |
| <p>Term definitions are as defined in the California Health and Safety Code § 1374.73</p> | | |

10. QUALITY

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement and Health Equity Transformation Program. You can contact the Molina Quality department toll free at (800) 526-8196, Ext. 126137.

The address for mail requests is:

Molina Healthcare of California
Quality Department
200 Oceangate, Suite 100
Long Beach, CA 90802

This Provider Manual contains excerpts from the Molina Quality Improvement and Health Equity Transformation Program. For a complete copy of Molina's Quality Improvement and Health Equity Transformation Program, you can contact your Provider Relations representative or call the telephone number above.

Molina has established a Quality Improvement and Health Equity Transformation Program that complies with regulatory requirements and accreditation standards. The Quality Improvement and Health Equity Transformation 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 and health equity transformation 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 and Health Equity Transformation Program in place.
- Comply with and participate in Molina's Quality Improvement and Health Equity Transformation 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 and health equity transformation 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 and health equity transformation 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) is 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 be maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components, which include but are not limited to:

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

Medical Record Keeping Practices

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

- Each patient has a separate record.

- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within 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 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 per record management processes.
- Process is in place for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

Providers must remain consistent in their practices with Molina’s medical record documentation guidelines. Medical records are maintained and should include, but not limited to the following information. All medical records should contain:

- The patient’s name or ID number on each page in the record.
- The patient’s name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of the Provider and other staff members within a paper chart.
- A list of all Providers who participate in the Member’s care.
- Information about services that are delivered by these Providers.
- A problem list that describes the Member’s medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 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 that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.

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

Organization

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

Retrieval

- The medical record is available to Provider at each encounter.
- The medical record is available to Molina for purposes of Quality improvement.
- The medical record is available to the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the Member upon their request.
- A storage system for inactive Member medical records which allows retrieval within 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 (1) 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.
- Protect Medical Records 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 see 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 three (3) types of Advance Directives:

- **Durable Power of Attorney for Health Care:** A written directive designating an individual (health care agent) to make health care decisions if the principal becomes mentally incapacitated.
- **Living Will:** A written directive in which an individual specifies choices for medical treatment.
- **5 Wishes:** records an end-of-life care plan for future care in case someone is unable to make decisions for themselves at that time.

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, eighteen (18) years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

Members who would like more information are instructed to contact Member Services 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.

Providers may not 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), Hematology/Oncologist (high-impact specialists), and behavioral health practitioners. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members. Providers are

required to meet all time-elapsed standards set forth in the Timely Access and Network Reporting Statutes and Regulation, including new standards for non-urgent mental health follow-up appointments. Provider who determines, while acting within the scope of his or her practice and consistent with professionally recognized standards, that the established wait time may be extended must note in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member.

As stated in HSC 1367.03(f)(1), Contracts between health care service plans and health care providers ensure compliance with the standards developed under this chapter. These contracts require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards. Additionally, Providers are obligated to supply the plan with accurate data, including all provider data required under Rule 1300.67.2.2(h) and the data described in the Instructions Manual.

Appointment Access

All Providers who oversee the Member’s health care are responsible for providing the following appointments to Molina Members within the noted timeframes. Molina will implement corrective actions for access to health care services that do not meet the performance standards.

Medical Appointment

| Appointment Types | Standard |
|-------------------------------------------------------------------------------------------|-------------------------------------------|
| Emergency Care | Immediately |
| PCP Urgent Care without prior authorization | Within ≤ 48 hours of the request. |
| PCP Urgent Care with prior authorization | Within ≤ 96 hours of the request. |
| PCP Routine or Non-Urgent Care Appointments | Within ≤ 10 business days of the request. |
| PCP Adult Preventive Care | Within ≤ 20 business days of the request. |
| Specialist Urgent Care without prior authorization | Within ≤ 48 hours of the request. |
| Specialist Urgent Care with prior authorization | Within ≤ 96 hours of the request. |
| Specialist Routine or Non-Urgent Care | Within ≤ 15 business days of the request. |
| Routine or Non-Urgent Care Appointment for Ancillary Services | Within ≤ 15 working days of the request. |
| Children’s Preventive Period Health Assessments (Well-Child Preventive Care) Appointments | Within ≤ 7 working days of the request. |
| After Hours Care | 24 hours/day; 7 day/week availability |

| Appointment Types | Standard |
|-------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maternity Care Appointments for First Prenatal Care | Within ≤ 2 weeks of the request. |
| Office Telephone Answer Time (during office hours) | Within ≤ 30 seconds of call. |
| Office Response Time for Returning Member Calls (during office hours) | Within same working day of call. |
| Office Wait Time to be Seen by Physician (for a scheduled appointment) | Should not exceed 30 minutes from the appointment time. |
| After-Hour Instruction for Life-Threatening Emergency (when office is closed) | Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911." |
| Physician Response Time to After-Hour Phone Message, Calls and/or Pages | Within 30 minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for Members. |

Behavioral Health Appointment

| Appointment Types | Standard |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Urgent Care with a Behavioral Health Provider without prior authorization | Within ≤ 48 hours of the request. |
| Urgent Care requiring prior authorization with a Behavioral Health Provider | Within ≤ 96 hours of the request. |
| Routine or Non-Urgent Care Appointments with a Behavioral Health Provider | Within ≤ 10 working days of the request. |
| Behavioral Health Non-life-threatening emergency | Within ≤ 6 hours of the request. |
| BH – Routine Follow Up with Prescribers (i.e., Psychiatrist) | Within ≤ 30 business days from the initial appointment for a specific condition |
| BH – Routine Follow Up with Non-Prescribers | Within ≤ 10 business days from the initial appointment with non-Prescribers (i.e., non-physician mental health care or substance use disorder provider) for a specific condition |
| Routine or Non-Urgent Care Appointment with a Non-Physician Mental Health Provider or substance use disorder providers | Within ≤ 10 working days of the request. |

After-Hour Availability

| After-hour Availability | After-hour Access Standards |
|------------------------------------------------------------|-----------------------------------------------------------------------|
| Appropriate after-hour emergency instruction. | If this is a life-threatening emergency, please hang up and dial 911. |
| Timely physician response to after hour phone calls/pages. | Within ≤ 30 minutes. |

Ancillary Appointment

| Ancillary Access Type | Ancillary Access Standards |
|------------------------------------------------|----------------------------|
| Non-urgent appointment for ancillary services. | Within ≤ 15 business days. |

If your office is unable to offer Member's appointments within the above standards, please contact Member Services at (888) 858-2150.

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

If you are unable to obtain a timely referral to an appropriate provider, please contact the DMHC Provider Complaint line toll-free at (877) 525-1295 or through their website at <https://www.dmhc.ca.gov/fileacomplaint/providercomplaintagainstaplan/submitaprovidercomplaint.aspx>.

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed thirty (30) minutes from the appointment time. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours Care and Emergencies

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a 24-hour phone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with a life-threatening Emergency to hang-up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

After-hour answering service or recorded message must provide a clear instruction on how to reach the physician or the designee (on-call physician) after business hours. Physician or the designee must respond to urgent after-hours phone calls, messages, and/or pages within thirty (30) minutes.

Women's 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 is reviewed, revised as necessary, and approved by the Quality Improvement and Healthy Equity Transformation Committee on an annual basis.

Provider Network adherence to access standards is monitored via one, or more, of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time and identification of barriers. Results of analysis are reported to the Quality Improvement and Healthy Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Healthy Equity Transformation 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 of an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility
- Physical Appearance

- Adequacy of Waiting and Examining Room Space

Physical Accessibility

Molina evaluates office sites, as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space

During the site visit, as required, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with Molina must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per physician.
- 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 are restricted.
- System in place to ensure expired sample medications are not dispensed and injectable and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all preventative services necessary for Enrollees under twenty-one (21) Years of age are timely according to required preventive health guidelines. All Enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the by the preventive health guidelines located on the Molina Provider website at MolinaMarketplace.com and referenced in the Benefits and Covered Services section of this Provider Manual.

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) is accessed by Members through the VSP network
- Hearing screening for preventive services
- Dental assessment and services
- Health education (including anticipatory guidance such as child development, healthy lifestyles, and 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, behavioral 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 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 Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Timely Access to Care: Sensitive and Confidential Services for Adolescents and Adults

Sensitive Services means those services related to:

- Sexual Assault
- Drug or alcohol abuse for children twelve (12) years of age or older
- Pregnancy
- Family Planning
- Sexually transmitted diseases for children twelve (12) years of age or older
- Abortion services
- HIV testing/counseling
- Mental Health Services
- Health Education Services

The following is a brief guide on providing access to Members for these sensitive areas.

Timely Access to Services and Treatment Consent

Members under the age of twelve (12) years require parental or guardian consent for obtaining services in the areas of sexually transmitted diseases or drug/alcohol abuse. Minors under the age of twelve (12) years seeking abortion services are subject to State and Federal law. Those age twelve (12) and over can obtain any and all of the above services by signing the Authorization for Treatment form. Timely access is required by Providers/Practitioners for members seeking the sensitive/confidential medical services for family planning and/or sexually transmitted diseases, HIV testing/counseling, as well as for confidential referrals for treatment of drug and/or alcohol abuse.

Family Planning Services

To enhance coordination of care, PCPs are encouraged to refer Members to MHC Providers/Practitioners for family planning. Members, however, do not require prior authorization from their PCP to seek family planning services. This freedom of choice provision is the result of Federal legislation.

Privacy and Security of Protected Health Information

Member and patient Protected Health Information (PHI) should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider/Practitioner may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. In addition, Providers/Practitioners must implement and maintain appropriate administrative, physical, and technical safeguards to protect the confidentiality of medical records and other PHI. Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. In general, most California health care Providers/Practitioners are subject to the following laws and regulations pertaining to privacy of health information:

- Federal Laws and Regulations
 - HIPAA
 - Medicare and Medicaid laws
- California Laws and Regulations
 - Confidentiality of Medical Information Act (CMIA)
 - Patient Access to Health Records Act (PAHRA)

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement and Health Equity Transformation Program. The Quality Improvement and Health Equity Transformation Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. 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 Management and Care Management subsections in 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 Clinical Practice Guidelines include the following:

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

All clinical practice guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Health

Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, clinical practice guidelines are distributed to Providers at [MolinaMarketplace.com](https://www.molinahealthcare.com/providers) (or when changes are made during the year), and the Provider Manual. Notification of the availability of the clinical practice guidelines is published in the Molina Provider Newsletter.

Preventive Health Guidelines

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

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on Molina’s website)
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on Molina’s website)
- 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. Links to current recommendations are included on Molina’s website.
- 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. Links to current recommendations are included on Molina’s website.

All preventive health guidelines are updated at least annually, and more frequently, as needed when clinical evidence changes, and are approved by the Quality Improvement and Equity Transformation Committee. In fact, a review is conducted at least monthly to identify new additions or modifications. On an annual basis, Preventive Health Guidelines are distributed to Providers via [MolinaMarketplace.com](https://www.molinahealthcare.com/providers) (or when changes are made during the year) and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Appropriate Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina’s program and services, please refer to the Cultural Competency and Linguistic 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®)
- Qualified Health Plan (QHP) Enrollee Experience Survey
- Behavioral 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's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement and health equity transformation 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 MolinaMarketplace.com.

Healthcare Effectiveness Data and Information (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, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to Federal and State regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

Qualified Health Plan (QHP) Enrollee Experience Survey

The QHP Enrollee Experience Survey is a consumer experience survey that assesses enrollee experience with QHPs offered through Marketplaces. The QHP Enrollee Survey is fielded nationally by HHS-approved survey vendors using a standardized protocol to facilitate QHP comparison both within and across Marketplaces.

The QHP Enrollee Experience Survey was designed to collect accurate and reliable information from consumers about their experience with the behavioral and non-behavioral health care they received through Health Insurance Marketplace QHPs. The survey includes a set of core questions that address key areas of care and service, with some questions grouped to form composites.

QHP Enrollee Survey topics include:

- Access to Care
- Access to Information
- Care Coordination
- Cost
- Cultural Competence
- Doctor’s Communication
- Plan Administration
- Prevention

Behavioral Health Satisfaction Assessment

Molina obtains feedback from Members about their experience, needs, and perceptions of accessing behavioral health care services. This feedback is collected at least annually to understand how our Members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are especially important to Molina, as this is one of the primary methods, we use 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.

Quality Rating System for Marketplace

Based on Section 1311(c) (3) of the Affordable Care Act, CMS developed the Quality Rating System (QRS) to:

- Provide comparable and useful information to consumers about the quality of health care services provided by QHPs.
- Facilitate oversight of QHP issuer compliance with Marketplace quality standards.
- Provide actionable information for improving quality and performance.

Quality ratings are calculated for each eligible QHP product using clinical quality and enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a 1-5-star rating scale.

Measures are organized into a hierarchical structure designed to make the QRS scores and ratings more understandable. They include, but are not limited, to the following domains:

- Clinical Effectiveness
- Patient Safety
- Prevention
- Access and Coordination
- Doctor and Care
- Efficiency and Affordability
- Plan Service

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 is a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department. HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

11. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

The Centers for Medicare & Medicaid (CMS) defines Risk Adjustment as a process that helps accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Molina Members and prepares for resources that may be needed in the future to treat Members who have multiple clinical conditions.

Why is Risk Adjustment Important?

Molina relies on our Provider Network to take care of our Members based on their health care needs. Risk Adjustment considers numerous clinical data elements of a Member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency
- Recognize and address current and potential health conditions early
- Identify Members for Care Management referral
- Ensure adequate resources for the acuity levels of Molina Members
- Have the resources to deliver the highest quality of care to Molina Members

Your Role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to utilize the annual visit (for all new and existing patients) to perform a comprehensive assessment of the chronic conditions and current health status. We encourage Providers to code all diagnoses to the highest specificity. This will ensure Molina receives adequate resources to provide quality programs to you and our Members.

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

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

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's electronic medical records (EMR), including, but not limited to, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). The CDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Molina Members to the interoperability vendor designated by Molina.

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have Direct Address, Provider will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) Requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with Molina's established interoperability partner to get an account established.

RADV Audits

As part of the regulatory process, Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Molina for risk adjustment is complete and accurate. All Claims/Encounters submitted to Molina are subject to State and/or Federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

For questions about Molina's Risk Adjustment programs, please contact your Provider Relations representative.

12. 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 program 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 of funds either by fraud, waste, or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and State Laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

These provisions encourage employees (current or former) and others to report instances of fraud, waste, or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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

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

Affected entities who fail to comply with the Law will be at risk of forfeiting all Medicaid payments until compliance is met. Molina will take steps to monitor Molina contracted Providers to ensure compliance with the Law.

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

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

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

What is AKS?

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

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

Marketing Guidelines and Requirements

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

Under **Molina’s policies**, Marketing means any communication, to a beneficiary who is not enrolled with Molina, which can 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 relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive “designated health services” payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission, or causing the submission, of Claims in violation of the law’s restrictions on referrals. “Designated health services” are identified in the Physician Self-Referral Law [42 U.S.C. § 1395nn].

Sarbanes-Oxley Act of 2002

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

Definitions

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

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

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

Examples of Fraud, Waste, and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering claims and/or medical record documentation 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 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 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 Fraud, Waste, and Abuse Detection Activities

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

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

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

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Molina, governmental agencies and their representatives or agents in a timeframe established by Molina, 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 services are provided to Molina Members and in a format consumable by Molina. 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, and determined by Molina and without charge to Molina. In the event Molina identifies fraud, waste or abuse is identified, Provider agrees to repay funds or Molina may seek recoupment.

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

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

Claim Auditing

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

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

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

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

If Molina's Special Investigations Unit suspects that there is fraudulent or abusive activity, 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

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

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

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

Molina Healthcare of California
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

Remember to include the following information when reporting:

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

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

CA Dept. of Health Services
PO Box 997413 MS 4400
Sacramento, CA 95899-7413

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

CMS Toll Free Phone: 1-800-MEDICARE (1-800-633-4227), or
Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Toll Free Phone: (800) 447-8477

TTY: (800) 377-4950

Fax (10 page max): (800) 223-8164

Online at the Health and Human Services Office of the Inspector General website at
<https://oig.hhs.gov/FRAUD/REPORT-FRAUD/INDEX.ASP>.

PRIVACY Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Molina 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 privacy of health information, including, without limitation, the following:

1. Federal Laws and Regulations

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

2. State Medical Privacy Laws and Regulations

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

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and 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 entity¹. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services²."
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

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

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

either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

- Quality Improvement
- Disease Management
- Case Management and Care Coordination
- Training Programs
- Accreditation, Licensing, and Credentialing

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

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing Federally assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2. *(Please note that the HHS Office for Civil Rights, in coordination with the Substance Abuse and Mental Health Services (SAMHSA), is expected to issue a rule that would implement Section 3221 of the CARES Act and better harmonize the 42 CFR Part 2 confidentiality requirements with HIPAA).*

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 (6)-year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security 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 MolinaMarketplace.com. For additional information regarding HIPAA standard transactions.

1. Click on the area titled "Providers"
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)

Provider 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

Providers who are delegated for Claims and Utilization Management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all

business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

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

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and 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 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 [3] 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 Provider, Provider shall maintain backups of such Molina Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.
 - (iii) Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.
- (c) Notification. Provider shall notify Molina's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed twenty-four (24) hours, of either of the following:
- i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Molina or that detrimentally affects Provider's Information Systems or Molina's Information.
 - ii. Provider's activation of business continuity plans. Provider shall provide Molina with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.
- (d) BC and DR Testing. For services provided to Molina, Provider shall exercise its BC/DR Plan at least once each calendar year. Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide Molina a written report in

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

4. Cybersecurity Events.

- (a) Provider agrees to comply with all applicable data protection and privacy laws and regulations. Provider will implement best practices for incident management to identify, contain, respond to, and resolve Cybersecurity Events.
- (b) In the event of a Cybersecurity Event that threatens or affects Molina's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or Molina Information accessible to or held by Provider, Provider shall notify Molina's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than twenty-four (24) hours from Provider's discovery of the Cybersecurity Event.
 - i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within twenty-four (24) hours following such payment.
 - ii. Within fifteen (15) days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.
- (c) Notification to Molina's Chief Information Security Officer shall be provided to:
Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802
- (d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable

for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two 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;

- xii. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
 - xiii. 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
 - xiiii. 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. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between Molina and Provider but are not contained in this section.
7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between Molina and Provider, the stricter of the conflicting provisions will control.

Business Contact Information

If you are a California resident, you may have certain rights with respect to the business contact personal information that you provide to Molina as a Provider, pursuant to the California Privacy Rights Act (CPRA), which amends the California Consumer Privacy Act (CCPA). For more information about those rights and how they may be exercised, please see the “California Business Contact Information” section of Molina’s Website Privacy Policy, available at https://www.molinahealthcare.com/members/common/en-us/terms_privacy.aspx.

13. CLAIMS AND COMPENSATION

| | |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------|
| Payer ID | 38333 |
| Availity | provider.MolinaHealthcare.com |
| Clean Claim Timely Filing | 90 Calendar Days, after the discharge for inpatient services or the Date of Service for outpatient services |

Electronic Claims 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](#) portal.
- Submit Claims to Molina via your regular EDI clearinghouse using payer ID 38333.

Availity

The [Availity](#) 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 Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and manage Claim Templates.
- Create and submit a Claim Appeal with attached files.

Clearinghouse

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

If you do not have a clearinghouse, Molina offers additional electronic Claims submissions options as shown by logging on to the [Availity](#) 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 representative 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 ninety (90) 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 ninety (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 CMS Provider billing guidelines. Providers must utilize electronic billing through a clearinghouse or the [Availity](#) portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 38333. 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.

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 under EDI>Companion Guides for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

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

The following information must be included on every Claim, 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)
- 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
- 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 Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

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

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

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

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

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Molina Healthcare of California
PO Box 22702
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 colored CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10- or 12-point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS:
<https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500>.

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](#) 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.
- Must include the original reference claim number (Internal Control Number/Document Control Number ICN/DCN)

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 365 calendar days of most recent adjudicated date of the Claim.

Corrected Claims submission options:

- Submit Corrected Claims directly to Molina via the [Availity](#) portal.
- Submit corrected Claims to Molina via your regular EDI clearinghouse.

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

Our benefit plans are subject to subrogation and COB rules.

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, Optum at submitreferrals@optum.com.

COB — Coordination of Benefits (COB) exists when an individual has more than one policy at the same time and order of benefits are established pursuant to national and/or state guidelines. Primary payers should be billed prior to Claim submission to secondary/tertiary payers to cover any remaining liability.

Workers’ Compensation — Workers' compensation is primary payer when a Member's damages are related to an incident that occurred while working. Claims related to a workers' compensation incident should be submitted to the carrier prior to submitting to Molina for payment.

Medicare — Medicare is the primary payer for covered services and providers accepting Medicare assignment except in the following instances:

- Members Entitled to Medicare due to Age: Commercial health plans are primary to Medicare if the employer has twenty (20) or more employees, and the Member is actively working.
- Disabled employees (large group health plan): Commercial health plans are primary to Medicare if the employer has 100 or more employees, and the Member is actively working.
- End-Stage Renal Disease (ESRD): If a Member is entitled to Medicare due to ESRD while covered under an employer’s group health plan, commercial group health plan is primary for the first thirty (30) months after becoming eligible for Medicare. After the thirty (30) months, Medicare is the primary payer. However, if the commercial group health plan was secondary to Medicare when the Member became entitled due to ESRD, Medicare will remain the primary payer and no thirty (30)-month coordination period is required.

Hospital-Acquired Conditions (HAC) and Present on Admission (POA) 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 – Mediastinitis
- 10) Surgical Site Infection Following Certain Orthopedic Procedures:
 - a) Spine
 - b) Neck
 - c) Shoulder
 - d) Elbow
- 11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
 - a) Laparoscopic Gastric Restrictive Surgery
 - b) Laparoscopic Gastric Bypass
 - c) Gastroenterostomy
- 12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
- 13) Iatrogenic Pneumothorax with Venous Catheterization

- 14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
 - a) Total Knee Replacement
 - b) Hip Replacement

What this means to Providers

- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information 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 MolinaMarketplace.com website under the Policies tab. Questions can be directed to your Provider Relations representative.

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 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). If a professional organization has a more stringent/restrictive standard than a Federal MUE, the professional organization standard may be used.
- Medicare National Coverage Determinations (NCD).
- 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.
- 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 Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.
- The charges billed: Molina will pay the lesser of billed charges or the contracted rate.

Telehealth Claims and Billing

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

All telehealth Claims for Molina Members must be submitted to Molina with correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to Molina's Telemedicine, Telehealth Services and Virtual Visits policy at [MolinaMarketplace.com](https://www.molinahealthcare.com/Marketplace).

Services as determined by the Provider's description of the service on the Claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan and the Provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

Molina will reimburse the treating or consulting health care Provider for the diagnosis, consultation, or treatment of a Molina Member appropriately delivered through telehealth services on the same basis and to the same extent that Molina is responsible for reimbursement for the same service through in-person diagnosis consultation, or treatment.

National Correct Coding Initiative (NCCI)

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

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by

the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (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 (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) 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 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective

on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) 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 Number (NDC)

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

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

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 (3) 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 ICD10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

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

Claim Auditing

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

Provider acknowledges Molina’s right to conduct 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, all supporting medical records, Provider’s charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records

upon Molina's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

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

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Molina asks that you provide us, or our 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 within thirty (30) days after receipt of Clean Claims.

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 MolinaMarketplace.com or by contacting our Provider Relations department.

Overpayments and Incorrect Payments Refund Requests

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

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

A copy of the overpayment request letter and details are available in the Availity Provider Portal. In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment, or check status. This is Molina's preferred method of communication.

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

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

A Provider shall pay a Claim for an Overpayment made by Molina which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider.

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

Claim Disputes/Reconsiderations/Appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the Complaints, Grievance, and Appeals Process 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 for more information.

Encounter Data

Each Provider, capitated Provider or organization delegated for Claims processing is required to submit Encounter data to Molina for all services provided to a Molina member. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least once per month, and within sixty (60) days from the date of service 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. Molina has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within the sixty (60) days from date of service.

Submitters of claims in electronic format must follow Molina's Companion Guide for the v5010 ASC X12N transactions (837P/I/D) with the specific submission requirements in addition to standard HIPAA X12 Implementation Guides requirements.

When Encounters are filed electronically Providers should receive two (2) types of responses:

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

Molina's Marketplace Payment Rate

Molina's Marketplace payment rate does not include any add on payments, adjustments or deductions that are only allowed for a Medicare Member, including but not limited to uncompensated disproportionate share hospital (DSH) payments, operating and capital DSH payments, operating and capital indirect medical education (IME) payments, direct graduate medical education expense payments and deductions for sequestration.

14. COMPLAINTS, GRIEVANCE AND APPEALS PROCESS

Grievances and Appeals

Member Appeals

A Member Appeal may be requested by the Member or their designee within 180 calendar days after the Member's receipt of the Denial, Modification or Delay Notice. Appeal on behalf of the Member by contacting the Molina Member Services department at (888) 858-2150.

What to do if you receive a:

- Pre-service or prior authorization denial for lack of information: Resubmit the request to UM with the UM requested additional information via the [Availity](#) portal, or fax to (800) 811-4804.
- Pre-service or prior authorization denial for lack of medical necessity, failure to meet criteria, non-benefit, modification, or delay: Appeal on behalf of the Member by contacting the Molina Member Services department at (888) 858-2150. Please have additional documentation available to support medical necessity of the requested service.
- Retrospective review request:
 - If less than thirty (30) days from the date of service rendered, please submit a service request form requesting retrospective review and documentation supporting medical necessity via the [Availity](#) portal or fax to (866) 553-9263.
 - If greater than thirty (30) days, but less than sixty (60) days from the date of service, please submit documentation supporting medical necessity for retrospective review through the [Availity](#) portal within sixty (60) days of the service being provided.
- Post-service or retrospective authorization denial: Appeal on behalf of the Member by contacting the Molina Member Services department at (888) 858-2150. Please have additional documentation available to support medical necessity of the requested service.
- Payment denial for any reason except for an unclean Claim: Appeal your payment denial within 365 days using the dispute resolution process.
- Non-payment for unclean Claims: Submit a clean Claim within the noted timeframe and with the information that is requested in the remit message.

Member Grievances or Complaints

A Grievance is an expression of dissatisfaction about matters other than an Adverse Benefit Determination, including but not limited to, the quality of care or services provided. If a Member has a problem with any Molina services, Members can contact Molina:

- Call Molina toll-free at (888) 858-2150, Monday through Friday, 8 a.m. to 6 p.m., TTY/TDD user may dial 711.
- Member may send the complaint in writing by mail, faxing, or filing online at:
 - MolinaMarketplace.com
 - Fax: (562) 499-0757

- Molina Healthcare, Inc.
Attn: Member Appeals & Grievances
200 Oceangate, Suite 100
Long Beach, CA 90802
- Information regarding PQOCs may be obtained by contacting Molina’s Quality department at (800) 526-8196.

Provider Claim Disputes – the “Appeals Process”

A Provider/Practitioner grievance or complaint is described in Title 22, California Code of Regulations (CCR), as a written entry into the appeals process. Molina maintains two (2) types of appeals:

- Appeals regarding non-payment or processing of Claims known as Provider Disputes.
- A Provider/Practitioner of medical services may submit to Molina an appeal concerning the modification or denial of a requested service or the payment processing or non-payment of a Claim by the plan. Molina will comply with the requirements specified in Section 56262, of Title 22 of the CCR, and Title 28, CCR, Sections 1300.71 and 1300.38.

Claims Settlement Practices and Provider Dispute Resolution

Appeals regarding modifications or denial of a pre-service request are considered Member appeals.

Provider Disputes

A Provider Dispute is defined as a written notice prepared by a Provider that:

- Challenges, appeals, or requests reconsideration of a Claim that has been denied, adjusted, or contested.
- Challenges Molina’s request for reimbursement for an overpayment of a Claim.
- Seeks resolution of a billing determination or other contractual dispute.

All Provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the Provider. For paper submission, Molina will acknowledge the receipt of the dispute within fifteen (15) working days and within two (2) working days for electronic submissions. If additional information is needed from the Provider, Molina has forty-five (45) working days to request necessary additional information. Once notified in writing, the Provider has thirty (30) working days to submit additional information, or the Claim dispute will be closed by Molina.

Providers may dispute by submitting and completing a Provider Dispute Resolution Request Form within 365 days from the last date of action on the issue. A written dispute form must include the Provider name, identification number, contact information, date of service, claim number, explanation for the dispute and all required documentation or proof to support the

dispute. Disputes with incomplete information and missing required documentation will not be processed. Molina will provide a written response to the provider within 45 working days from the date of the dispute and allows two levels of dispute.

How to Submit Provider Disputes

Method 1: [Availity](#) portal (most preferred method):

- Log onto the Availity at: provider.MolinaHealthcare.com
- Search and identify adjudicated Claim and submit a dispute/appeal
- Complete required information on the [Availity](#) portal and upload required documents or proof to support the dispute

Method 2: Fax to (562) 499-0633

Method 3: Mail to

Molina Healthcare of California
Attn: Provider Dispute Resolution Unit
PO Box 22722
Long Beach, CA 90801

Provider Claim Disputes/Appeals Involving Shared Risk Capitated IPAs/Medical Groups

If an appeal involves a Member who is assigned to a Primary Care Practitioner (PCP) or IPA/Medical Group under a shared-risk capitated compensation agreement, Molina will delegate the first level of Claim dispute/appeal to the IPA/Medical Group. Molina does not delegate the second level dispute/appeals. However, Molina will make the final determination on all Claim disputes/appeals received from Providers/Practitioners. All first level disputes/appeals should be submitted directly to the participating IPA/Medical Group. All first level disputes/appeals received by Molina will be forwarded to the IPA/Medical Group upon receipt. The IPA/Medical Group will review the appeal and make a decision in accordance with contract and applicable regulation.

If the decision is to overturn the original Claim denial, the IPA/Medical Group will respond to the Provider/Practitioner and pay the Claim. If the determination is to continue to uphold the denial, Provider/Practitioner may appeal the first level Claim dispute/appeal decision by submitting an appeal to Molina or its affiliated health plan for a second level dispute/appeal determination. If Molina upholds the denial, the Provider/Practitioner will be notified of the second level dispute/appeal decision at that time.

Balance Billing

Molina prohibits Providers/Practitioners or delegated Provider from balance-billing a Member when the denial disputed is upheld. The Provider/Practitioner is expected to adjust off the

balance owed if the denial is upheld in the appeals process. Furthermore, according to Assembly Bill (AB) 72, non-network Providers providing services in a contracted facility, may not balance bill a Member under any circumstances.

Reporting

Grievance and appeal trends are reported to the Quality Improvement and Healthy 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 Healthy Equity Transformation Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

15. 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 your Molina provider Relations representative.

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

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). In accordance with those standards, Molina Members will not be referred and/or assigned to you until the credentialing process has been completed and added to the Health Plan Systems. The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

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

Types of Practitioners Credentialed & Recredentialled

Practitioners and groups of Practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

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

- Master’s-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

HIV/AIDS Specialist

Molina requires Practitioners to submit a complete, signed and dated HIV/AIDS Specialist form to identify appropriately qualified specialists who meet the definition of an HIV/AIDS specialist under California Code of Regulations Section 1374.16 of the Act.

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.

Providers shall not be eligible to see Molina Members as Participating Providers until notified of their effective date from Molina.

Additionally, Providers shall not be eligible to treat Members as a Participating Provider at a location until both notified of credentialing completion and added to the Health Plan systems. The Provider will receive a welcome notice from Molina with the effective date of participation, along with a copy of the fully executed agreement for new contract execution (if applicable). A Molina Provider Relations representative is assigned to each Provider's office. You may reach your representative by referencing the Provider Relations contact grid under the Contact Information section of this Provider Manual.

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.
- **DEA or CDS Certificate** – Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every State where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA and/ or CDS certificate and never had any disciplinary action taken related to their DEA and/or CDS or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty** – 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 training program in the specialties in which they are practicing. Molina only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a

training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three-(3) year residency or is not board certified, the podiatrist must have five (5) years of work history practicing podiatry.

- **Fellowship Training** – If the 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 (5) 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 (5) 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 the most recent five (5) 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 (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in

the Practitioner's credentialing file. If the gap in employment exceeds one (1) 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 body³. 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.

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

- **Medicare 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 Practitioners 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 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).

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 submitted 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’s 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 ten (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
PO Box 2470
Spokane, WA 99210.

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

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

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

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

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

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

Practitioner's Right to be Informed of Application Status

Practitioners have 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 included in this Provider Manual. Molina will respond to the request within two (2) 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.

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 thirty (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 immediately terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High Risk List** – Monitor for individuals or facilities who refused to enter into 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)** – Monitor 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

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.

16. 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. Sanction Monitoring for employees and contracted staff at all levels
4. Claims and Provider Dispute Resolution

When Molina delegates any clinical or administrative functions, Molina remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Molina's established delegation criteria and standards. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Molina's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly, quarterly, and ad hoc reports in a format determined by Molina. 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 take other actions, including sanctions and revocation of 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.

This section contains information specific to Molina's delegation criteria. Molina may delegate certain administrative responsibilities upon meeting all of Molina's delegation criteria. Molina is accountable for all aspects of the Member's health care delivery, even when it delegates specific responsibilities to sub-contracted entities. Molina's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.

If you have additional questions related to delegated functions, please contact your Molina Contract Manager.

Delegation Criteria

Credentialing

Credentialing functions may be delegated to entities which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions. To be delegated for credentialing functions, Providers must:

- Pass Molina’s credentialing pre-assessment and annual audits, which are based on NCQA credentialing standards and applicable state and federal regulations.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval, or denial/termination of practitioners included in delegation.
- Have an ongoing monitoring process in place that screens all practitioners included in delegation against OIG and SAM exclusion lists a minimum of every thirty (30) days.
- Correct deficiencies within timeframes approved by Molina when issues of noncompliance are self-reported by a delegated entity or identified by Molina.
- Agree to Molina’s contract terms and conditions and applicable accreditation standards for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contract or as communicated by Molina comply with all applicable Federal and State Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina in a timely manner with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.

Note: At its discretion, Molina may conduct a modified pre-assessment audit if the Provider is an NCQA Certified or Accredited organization. Modifications to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable state requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA accredited or certified in Credentialing functions or demonstrate an ability to meet all Health Plan, NCQA, and State and Federal requirements identified above. A written request must be completed to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, Credentialing Committee Minutes, Ongoing Monitoring documentation, and a process to implement corrective action if issues of noncompliance are identified.

An entity may request Credentialing delegation from Molina through Molina’s Delegation Oversight department or through their Contract Manager. Molina will ask the potential delegate to submit a Credentialing Pre-Delegation survey, policies and procedures for review

and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Molina retains the right to make the final decision to delegate Credentialing responsibilities and all decisions based on the entity's ability to meet Molina, State and Federal requirements for delegation.

Utilization Management

Utilization Management (UM) functions may be delegated to entities that meet National Committee for Quality Assurance (NCQA) criteria, regulatory and Molina established standards for utilization management functions and processes.

To be delegated for utilization management functions, the potential delegates must at minimum:

- Pass Molina's Utilization Management pre-assessment and annual audits, which are based on regulatory, NCQA UM and Molina established standards and state and federal regulatory requirements.
- Have a multi-disciplinary Utilization Management Committee who is responsible for oversight of the UM program, review and approval of UM policies and procedures and ensuring compliance of the UM processes and decisions.
- Have a full time Medical Director responsible for the UM program who holds an unrestricted license to practice medicine in California.
- Have internal controls and quality monitoring of work performed by the UM staff.
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a state or federal regulatory agency.
- Agree to and cooperate with Molina's contract terms and conditions for utilization management delegates.
- Submit timely and complete Utilization Management delegation reports in a format and frequency determined by Molina.
- Comply with all applicable accreditation and regulatory standards and applicable Federal and State Laws.
- Provide a ninety (90)-day advance notification to MHC of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process.
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.
- Comply with contractual, regulatory, and legal requirements for member and provider notification of utilization management decisions.
- Prohibit the use of verbal denials and other intangible methods of documenting physician review unless otherwise allowed by regulation or law.

Claims

Claims functions may be delegated to entities that demonstrate the ability to meet regulatory and Health Plan requirements for Claims functions.

To be delegated for Claims functions, the potential delegates must at minimum:

- Pass Molina’s Claims pre-assessment and annual audits, which are based on state and federal laws and regulatory and Molina established standards.
- Have internal controls and quality monitoring of work performed by Claims staff.
- Correct deficiencies within Molina established timeframes when issues of non-compliance are identified by Molina or a State or Federal regulatory agency.
- Agree to Molina’s contract terms and conditions for Claims delegates.
- Submit timely and complete Claims delegation reports as detailed in the Delegated Services Addendum or as communicated by Molina to the applicable Molina contact.
- Comply with all regulatory standards and applicable Federal and State Laws for Claims administration.
- Have systems enabled to accurately and timely adjudicate professional and facility claims, including but not limited to the appropriate application of interest penalties, claims appropriate edits, audit trail, fee schedule, Provider contracting status, denial codes, payment codes, pend codes and accumulators.
- Report member Claims accumulator data in a format and frequency determined by Molina.
- Provide a ninety (90)-day advance notification to Molina of its intent to sub-delegate and include pre-delegation review/results and delegate oversight process.
- In a timely and appropriate manner, respond, cooperate, and participate when applicable, in Health Plan, legal and regulatory inquiries and audits.

Oversight Monitoring of Delegated Functions

Prior to approval of delegation, and at least annually thereafter, Molina conducts an onsite/virtual review of potential delegates requesting delegation. MHC uses delegation standards and practices in compliance with NCQA, State and Federal Requirements. A member or designee of the Delegation Oversight team assigned to evaluate and oversee the delegate’s activities conducts the audit. Based on the audit scores and findings, if required thresholds and criteria are met, the appropriate Committee may approve specific delegation of functions. Once approved for delegation, an “Acknowledgement Acceptance of Delegation” must be signed between Molina and the Delegated Entity. For delegation of utilization management, a “Delineation of Utilization Management Responsibilities” grid is included with the Acknowledgement and Acceptance of Delegation,” outlining the delegated activities; Molina’s Responsibilities; the Delegated Entity’s Responsibilities; the Frequency of Reporting; Molina’s Process for Evaluating Performance; and Corrective Actions if the IPA/Medical Group fails to meet its responsibilities. Ad-hoc audits may be conducted at the discretion of the Health Plan.

Molina reserves the right to request corrective action plans, impose administrative or financial sanction and/or revoke the delegation of these responsibilities when the Delegated Entity demonstrates noncompliance to NCQA, contractual, State and Federal Requirements.

Complex Case Management services are not delegated. Molina Medical Case Management Department retains sole responsibility for authorization and implementation of these services.

Delegated Entities are required to refer known or potential cases to Molina Case Management. The referral may be made by a telephone or facsimile. This information can also be found in the Medical Management Section and in the Public Health Coordination and Case Management.

Member Confidential Communication

To the extent applicable to the function delegated, the Delegated Entity shall comply with the requirements of California Civil Code Section 56.107, and any other similar laws, which provide Members with the right to confidential communications, including confidential communications with respect to certain sensitive services (“Confidential Communications”). The Delegated Entity shall comply with any direction by Molina with respect to Confidential Communications with a designated Member. If the Delegated Entity oversees delivery or transmission of Confidential Communications, responding to a Member’s request for Confidential Communications, or other services involving Confidential Communications, the Delegated Entity shall comply with Molina’s policies, procedures, manuals, and instructions regarding Confidential Communications including, but not limited to the following requirements:

Delegated Entity shall not require a protected individual to obtain the Subscriber’s, or other Member’s authorization to receive sensitive services or to submit a Claim for sensitive services if the protected individual has the right to consent to care.

Delegated Entity shall recognize the right of a protected individual to exclusively exercise rights granted under the California Confidentiality of Medical Information Act regarding medical information related to sensitive services that the protected individual has received.

Delegated Entity shall direct all communications regarding a protected individual’s receipt of sensitive services directly to the protected individual receiving care as follows:

- If the protected individual has designated an alternative mailing address, email address, or telephone number pursuant to a Confidential Communications request, Delegated Entity shall send or make all communications related to the protected individual’s receipt of sensitive services to the alternative mailing address, email address, or telephone number designated.
- If the protected individual has not designated an alternative mailing address, email address, or telephone number pursuant to a Confidential Communications request, the Delegated Entity shall send or make all communications related to the protected individual’s receipt of sensitive services in the name of the protected individual at the address or telephone number on file.

Communications subject to confidential communication requirements include the following written, verbal, or electronic communications related to the receipt of sensitive services:

- (i) Bills and attempts to collect payment.
- (ii) A notice of adverse benefits determinations.
- (iii) An explanation of benefit notice.
- (iv) A Delegated Entity’s request for additional information regarding a claim.

- (v) A notice of a contested claim.
- (vi) The name and address of a provider, description of services provided, and other information related to a visit.
- (vii) Any written, oral, or electronic communication from a Delegated Entity that contains protected health information.

Delegated Entity shall not disclose medical information related to sensitive health care services provided to a protected individual to the Subscriber or any Molina Members other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

Molina reserves the right to audit the delegated entity’s operations to confirm compliance with the requirements contained herein.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to Molina Delegation Oversight department in a timeline and format indicated by Molina. For a copy of Molina’s current delegation reporting requirements, please contact your Molina Contract Manager.

PCP Termination and Member Reassignment Policy

The guidelines outlined in this policy are intended to retain the accuracy of our network while keeping the Members care as a priority. Scenarios outside of this policy will be researched and decisions will be made in the best interest of the member.

Directly Contracted PCPs

| Scenario | Action |
|--------------------------------------------------|--------------------------------------------|
| Terminating PCP practices under a group contract | Members will remain with the Group |
| Terminating PCP practices under a solo contract | Member will be assigned within the Network |

IPAs/ Medical Groups

| Scenario | Action |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| Terminating PCP practices in a Federally Qualified Health Center (FQHC) | Member will remain with the FQHC |
| Federally Qualified Health Center (FQHC) is moving from one IPA to another | Member will remain with the FQHC |
| Terminating PCP is a solo practitioner and is affiliated with multiple IPA | Member will remain with the PCP and be transitioned to the still contracting IPA to ensure members continuity of care. |

| Scenario | Action |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| If PCP is being admiratively terminated by Molina or the IPA for such reasons as malpractice insurance, suspension of license, or failure to pass Facility Site Review | Member will remain with the IPA |
| If an IPA wishes to have members reassigned to PCPs within the IPA at time of provider termination, The IPA must make those assignments know at the time of notice. | Molina will make every effort to accommodate the request subject the Members right to choose their PCP. |

17. PHARMACY

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide Members with high-quality, cost-effective drug therapy. Molina collaborates with Providers and Pharmacists 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. Additional information regarding the pharmacy benefits, limitations, and network pharmacies is available by visiting MolinaMarketplace.com or calling Molina at (855) 322-4075.

Drug Formulary

The pharmacy program does not cover all medications. 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 Members can get from a pharmacy. Some medications require prior authorization (PA) or have limitations on age, dosage and/or quantities. For a complete list of covered medications please visit MolinaMarketplace.com.

Information on procedures to obtain these medications is described within this document and also available on the Molina website at MolinaMarketplace.com.

Formulary Medications

In some cases, Members may only be able to receive certain quantities of medication. Information on limits is included and can be found in the formulary document.

Formulary medications with PA may require the use of first line medications before they are approved.

Quantity Limitations

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) alerts 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 these 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

Non-formulary 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 the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), the form is available on MolinaMarketplace.com. Clinical evidence must be provided and is considered 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 available. If the use of a particular brand name becomes medically necessary as determined by the Provider, a 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

Medications not covered by Molina Marketplace are excluded from coverage. For example, drugs used in the treatment of fertility or those used for cosmetic purposes are not part of the benefit. For a complete list of drugs excluded from the plan benefit please refer to the Member's Evidence of Coverage.

Submitting a Prior Authorization Request

Molina will only process completed request forms; use the Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211). 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.

Molina'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 Molina will either 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 Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211) in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211) to Molina at (866) 508-6445. A blank Medication 61-211 Prescription Drug Prior Authorization or Step Therapy Exception Request form may be obtained by accessing MolinaMarketplace.com or by calling (855) 322-4075.

Providers and office staff can review Molina Clinical Criteria and Clinical Policies online to ensure all required information is submitted for review.

Site of Care for Administered Drugs

For Provider-administered drugs that require prior authorization, when coverage criteria are met for the medication, a site of care policy is used to determine the medical necessity of the requested site of care. Molina covers injectable and infused medications in an outpatient hospital setting or at a hospital-affiliated infusion suite when the level of care is determined to be medically necessary. To review the site of care policy, please visit MolinaMarketplace.com.

Molina may conduct 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.

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) J-codes via electronic medical Claim submission.

Molina, during the utilization management review process, 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.

If it is determined to be a Pharmacy benefit, Molina’s pharmacy vendor, CVS Caremark Specialty Pharmacy, 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 the Molina Pharmacy and Therapeutics Committee render a coverage decision. “Buy-and-bill” drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursements.

Molina Clinical Services completes Utilization Management for certain Healthcare Administered Drugs. Any drugs on the prior authorization list that uses a temporary C code, or other temporary HCPCS code that is not unique to a specific drug, may still require prior authorization for such drug even after it has been assigned a new HCPCS code.

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 MolinaMarketplace.com under the Health Resource tab. Please consult with your Provider Relations representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

COVID Drug Coverage

Molina covers recommended oral and infused therapies for the management of COVID (SARS-CoV-2 virus) in line with regulations and FDA-approved uses. During declared public health emergencies coverage for these therapies may be updated frequently in keeping with changing guidance. Be sure to check coverage documents for the most up-to-date details by visiting MolinaMarketplace.com. Coverage and requirements for prescription drugs can be found on our drug list. Coverage and requirements for clinician-administered drugs can be found by treatment-specific HCPCS code using our prior authorization lookup tool.