PROVIDER MANUAL

(Provider Handbook)

Molina Healthcare of Michigan, Inc.

(Molina Healthcare or Molina)

Molina Marketplace

2025

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.

Last Updated: 06/2025

MOLINA® HEALTHCARE

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1. Marketplace Products

Molina Marketplace Plan Information

Molina offers two (2) levels of affordable health plans for Molina Members:

- Silver
- Gold

2. Contact Information

Molina Healthcare of Michigan, Inc.
880 West Long Lake Rd, Suite 600
Troy, MI 48098

Provider Services

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

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

EDI Payer ID Number: 38334

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

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

Phone: (855) 322-4077
Availity portal: provider.molinahealthcare.com
Hearing Impaired (TTY/TDD): 711

Provider Relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education and training. The department has Provider Relations representatives who serve all of Molina's Provider network.

Phone: (855) 322-4077

Member Services

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

Phone: (888) 560-4087

Hearing Impaired (TTY/TDD): 711

Claims

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

- EDI Payer ID 38334

To verify the status of your Claims, please use the Availity portal. Claim questions can be submitted through the Secure Messaging feature via the Claim Status module on the Availity portal, or by contacting the Molina Provider Contact Center. For additional information please refer to the **Claims and Compensation** section of this Provider Manual.

Phone: (855) 322-4077

Claims Recovery

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

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

Compliance and Fraud Alertline

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

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

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

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (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 please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

24-hour Nurse Advice Line

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

Phone: (888) 275-8750
TTY/TDD: 711 Relay

Health Care Services

The Health Care Services (HCS) department conducts concurrent review on inpatient cases and processes prior authorizations/service requests. The HCS department also performs care management for Members who will benefit from care management services.

Participating Providers are required to interact with Molina's HCS department electronically whenever possible. Prior authorizations/service requests and status checks can be easily managed electronically. For additional information please refer to the **Health Care Services** section of this Provider Manual.

Managing prior authorizations/service requests electronically provides many benefits to Providers, such as:

- Easy to access 24/7 online submission and status checks
- Ensures Health Insurance Portability and Accountability (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.

Availity portal

Phone: (855) 322-4077
Fax: (833) 322-1061

- Advanced imaging: (877) 731-7218
- Transplants: (877) 813-1206

Health Management

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

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 our covered services for behavioral health. For Member behavioral health needs, please contact us directly at (855) 322-4077. 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 Member ID card.

Pharmacy

The prescription drug benefit is administered by Molina through CVS Caremark. A list of in-network pharmacies is available on the MolinaMarketplace.com website or by contacting Molina at (855) 322-4077. For additional information please refer to the **Pharmacy** section of this Provider Manual.

Quality

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

Phone: (866) 449-6828
Fax: (248) 925-1732

Molina Healthcare of Michigan, Inc. Service Area

3. Provider Responsibilities

Non-discrimination 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

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

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

Facilities, Equipment, Personnel and Administrative Services

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA) required element.

Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claim processing.

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

Failure to do so may result in your REMOVAL from the Marketplace Provider directory. 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)

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 MHMContractConfigDept@MolinaHealthcare.com or MHMDelegationOversight@MolinaHealthcare.com
- All other Providers must log into your Council for Affordable Quality Healthcare, Inc., (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 Services representative for assistance.

Additionally, in accordance with the terms specified in your Provider Agreement with Molina, Providers must notify Molina of any changes as soon as possible, but at minimum 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 with Molina.

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 its 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 Claim submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claim 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 required to comply with Molina's electronic solution policy by enrolling for EFT/ERA payments and registering for the Availity portal within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain an 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 Claim submission options
- Electronic payment: EFT with ERA
- Availity portal

Electronic Claim Submission Requirement

Molina strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claim 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 Claim submission options:

- Submit Claims directly to Molina via the Availity portal.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38334, 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 Claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims

Availity portal Claim submission includes the ability to:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claim 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 Requirement

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

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

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via virtual card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment (EOP) 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 Michigan be opted out of virtual cards.

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

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

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

Once your account is activated, you will begin receiving all payments through EFT and you will no longer receive a paper 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 Portal

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 Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files
  - Correct/void Claims
  - Add attachments to previously submitted Claims
  - Check Claim status

    - View ERA and 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 prior authorization/service requests
- Download forms and documents
- Send/receive secure messages to/from Molina

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

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Molina to the Provider. Balance billing a Member for covered services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Member Rights and Responsibilities

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

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

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by Molina prior to use.

Please contact your Provider Relations representative for information and review of proposed materials.

Member Eligibility Verification

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

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

- Availity portal
- Molina Provider Contact Center automated IVR system at (855) 322-4077

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

Health care services (utilization management and care management)

Providers are required to participate in and comply with Molina's utilization management and care management programs including all policies and procedures regarding Molina's facility admission, prior authorization and 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.

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

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

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

Specialty Services

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

Providers should direct Molina Members to health professionals, hospitals, laboratories and other facilities and Providers which are contracted and credentialed (if applicable) with Molina.

In the case of urgent and emergency services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and hospital emergency room. There may be circumstances in which specialty services may require an out-of-network Provider. Prior authorization will be required from Molina except in the case of emergency services.

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

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

Treatment Alternatives and Communication with Members

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

Pharmacy Program

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

Participation in Quality Improvement Programs

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

- Access to care standards
- Site and medical record-keeping practice reviews as applicable
- Delivery of patient care information

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

Compliance

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

Confidentiality of Member Health Information and HIPAA Transactions

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

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's grievance program and cooperate with Molina in identifying, processing and promptly resolving all Member complaints, grievances or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records, and/or statement, 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 please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Delegation

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

Primary Care Provider 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, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaMarketplace.com, from your local Provider Relations representative, and by calling the Molina Provider Contact Center at (855) 322-4077.

Nondiscrimination in Health Care Service Delivery

Molina complies with Section 1557 of the ACA. As a Provider participating in Molina's Provider network you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); state law; and federal program rules, including Section 1557 of the ACA.

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

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found in the Member Agreement and Individual Certificate of Coverage located at MolinaMarketplace.com/marketplace/mi/en-us/MemberForms.
3. You **MUST** post in a conspicuous location in your office a Tagline Document, that explains how to access non-English language services. A sample of the Tagline

Document that you will post can be found in the Member Agreement and Individual Certificate of Coverage located at MolinaMarketplace.com/marketplace/mi/en-us/MemberForms.

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

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

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

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

Provider and Community Training

Molina offers educational opportunities in cultural competency concepts for Providers, their staff and community-based organizations. Molina conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Relations and/or

online/web-based training modules. Web-based training modules can be found on Molina's website at Molinamarketplace.com.

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
4. Integration of cultural competency concepts and non-discrimination of service delivery into Provider communications

Integrated Quality Improvement

Molina ensures Member 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 that are congruent with cultural norms, Molina supports Members with disabilities, and assists Members with LEP.

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

Key Member information including appeal and grievance forms are also available in threshold languages on the Molina Member website.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling the Molina Member Contact Center toll free at (888) 560-4087. If Molina Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified language service Provider.

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

All eligible Members who are 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 individual with LEP 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 work 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 LRP: The Molina Member Contact Center representative will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Documentation

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

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

Members Who Are Deaf or Hard of Hearing

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

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

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

24-hour Nurse Advice Line

Molina provides nurse advice services for Members 24 hours per day, 7 days per week. The 24-hour Nurse Advice Line provides access to 24 hour interpretive services. Members may call Molina's 24-hour Nurse Advice Line directly at 888) 275-8750 (English) or 866) 648-3537 (Spanish), or TTY/TDD 711. The 24-hour Nurse Advice Line telephone numbers are also printed on Molina Member ID cards.

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).
- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider network.
- 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 Qualified health Plan 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 and on the Molina website.

The Member Handbook that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Handbook can be found on the Member pages of Molina's website at MolinaMarketplace.com/marketplace/mi/en-us/Members/Members-Resources.

The most current Member Rights and Responsibilities can be found on the Member pages of Molina's website at MolinaMarketplace.com/marketplace/mi/en-us/Members/Quality-Service/rights.

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 the Molina Member Services at (888) 560-4087, Monday through Friday, 8 a.m. to 5 p.m. Eastern time, excluding state and federal holidays. TTY/TDD users, please call 711.

Second Opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request a second opinion from another Provider. Members should call the Molina Member Contact Center 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:

- Availity portal
- Molina Provider Contact Center automated IVR system at (855) 322-4077

Possession of a Molina Member 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

Members are reminded in their Agreement to present ID cards when requesting medical or pharmacy services. The Molina Member 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

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

Non-APTC Member: A Member who is not receiving any advanced premium tax credits 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 both APTC Members and Non-APTC 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 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 Non-APTC Members 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-APTC Members

Non-ATPC Members are granted a 31-day grace period, during which they may be able to access some, or 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-APTC Member will be terminated as of the last day of the grace period.

APTC Members

APTC Members are granted a three (3)-month grace period. During the first month of the grace period Claims and authorizations will continue to be processed, including Pharmacy Claims. Services, authorization requests and Claims may be denied or have certain restrictions during the second and third months of the grace period. If the APTC Member's *full past-due premium* is not paid by the end of the third month of the grace period, the APTC Member will be retroactively terminated to the last day of the first month of the grace period.

Eligibility Messages

When a Member is in the grace period, Molina will include an eligibility message on the Availity portal, interactive voice response (IVR) and in the call centers. This message will provide information about the Member's grace period status, including which month of the grace period that the Member is in (first month vs. second or 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 messages 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 Evidence of Coverage, or contact the Molina Provider Contact Center at (855) 322-4077.

Notification

All Members will be notified upon entering the grace period. Additionally, when an APTC Member enters the grace period, the Member's eligibility status becomes available on the Availity portal. The online eligibility notification will inform 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 Providers will see upon checking the Availity portal will read as follows: No Enrollment Restrictions.
- Providers will be notified and are able to check that the APTC Member entered the second or third months of the grace period.
- All Providers, and specifically Providers who have submitted Claims for the APTC Member in the two (2) months prior to the start of the grace period will be notified and are able to check that the APTC Member entered the second or third months of the grace period.
- Providers will be notified and are able to check if the APTC Member is in the second or third months of the grace period before services are rendered and before submitting Claims.

The online eligibility 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 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.

If permitted under state law, Molina Healthcare will pend claims for services provided to Marketplace members in months 2 & 3 of the Federally required 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 Healthcare."

APTC Members

If the APTC Member pays the full premium payment prior to the expiration of the three (3)-month grace period, Providers may then seek authorization for services.

If the APTC Member received services during the second or third month of the grace period without a prior authorization, the Provider may request a retro-authorization for those services already rendered. All authorization requests will be reviewed based on medical necessity.

Non-APTC Members

Authorization requests received during a Non-APTC Member's grace period will be processed according to medical necessity standards.

Claims Processing

APTC Members

First Month of Grace Period: Clean Claims received for services rendered during the first month of a 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 Member's grace period will be pended until the premium is paid in full. In the event that the APTC 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 APTC Member will be charged 100% of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-APTC Members

Clean Claims received for services rendered during the 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 Schedule of Benefits documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located at on the MolinaMarketplace.com website and Availity portal. You may also contact the Molina Provider Contact Center at (855) 322-4077, Monday through Friday, 8 a.m. to 5 p.m., Eastern time, excluding state and federal holidays.

Verification of Benefits

Detailed information about benefits and services can be found in the Schedule of Benefits made available to Molina Marketplace Members via the Molina Member Portal. Providers can access Schedule of Benefits documents via the Availity portal.

Member Cost Share

Cost sharing is money that Members pay out of pocket for covered services according to the plan design they have signed up for. Members may be required to meet a deductible for some covered services. A deductible is money a Member must pay out of pocket for a covered service before the plan starts paying for that service. Not all services have a deductible requirement. Besides the deductible, Members will have cost sharing for most covered services. Depending on the plan design, the cost sharing will be a flat dollar amount (copayment), or percentage of the amount the provider is being paid (coinsurance) for covered services they are receiving. The cost sharing amount that Members will be required to pay for each type of covered service is summarized on the Schedule of Benefits. Information for some services is found on the Molina Member ID card. Cost sharing applies to all covered services except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act). State or federal laws that apply to Marketplace may reduce or eliminate cost sharing for other services.

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

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

Non-Formulary Drug Exception Request Process

A request for a formulary exception must be submitted using the same forms and procedures as submitting a prescription drug prior authorization request. The information submitted should show the Member factors and medical reasons why formulary drugs are not right for them. A copy of the Drug Formulary and Guide is found in the Provider Drug List section of MolinaMarketplace.com.

Formulary exceptions can be designated as urgent to expedite the review process and timeframe:

- Expedited Exception Requests are for urgent circumstances that may seriously jeopardize life, health or ability to regain maximum function, or for undergoing current treatment using the requested drug. Drug samples will not be considered as current treatment.
- Standard Exception Requests are for circumstances that do not meet the definition of urgent

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. 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 Prior Authorization 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.

Access to Behavioral Health Services

Behavioral health services are a direct access benefit and are available with no referral required. Health care professionals may assist Members in finding a behavioral health Provider or Members may contact the Molina Member Contact Center at (888) 569-4087. Molina's 24-hour Nurse Advice Line is available 24 hours a day, 7 days a week, 365 days per year for mental health or substance abuse needs. The services Members receive will be confidential.

Additional information regarding covered services and any limitations can be obtained in the benefit information linked above or by contacting Molina. If inpatient services are needed, prior authorization must be obtained, unless the admission is due to an emergency situation, and inpatient Member cost sharing will apply.

Emergency Mental Health or Substance Use Disorder Services

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

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

Emergency Services When Out of the Service Area

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 Molina Member ID card.
- Call Member's PCP and follow-up within 24 to 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 Molina Member ID card for additional benefit information and may be asked to transfer Members to an in-network facility when the Member is stable.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. 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 at MolinaMarketplace.com/marketplace/mi/en-us/Providers/Health-Resources.

Nurse Advice Line

Members may call the 24-hour 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, 365 days a year.

Molina is committed to helping our Members:

- Prudently use the services of your office
- Understand how to handle routine health problems at home
- Avoid making non-emergent visits to the emergency room

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 24-hour Nurse Advice Line. The 24-hour Nurse Advice Line may refer back to the PCP, a specialist, 911 or the emergency room. 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 sharing.
- 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.

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 decisions.

Key Functions of the UM Program

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

- **Eligibility and Oversight**
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to Member's medical necessity need(s) and 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 Center for Medicare & Medicaid (CMS), NCQA, state and health plan UM standards

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

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

UM Decisions

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

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

Board-certified licensed reviewers from appropriate specialty areas are utilized to assist in making determinations of medical necessity as appropriate. All utilization determinations are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with federal 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 Molina Member.

Providers can contact Molina's HCS department at (855) 322-4077 or via fax at (833) 322-1061 to obtain Molina's UM Criteria.

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

Medical Necessity

"**Medically Necessary**" or "**Medical Necessity**" means a denial of covered medical benefits as defined by Molina, including hospitalization and emergency services, as listed in the Evidence of Coverage-Summary of Benefits, or care or service that could be considered a covered benefit depending on the circumstances.

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.
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 generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

Cite AutoAuth can be accessed via the Availity portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available. Clinical information submitted with the prior authorization will be reviewed by Molina. This system will provide quicker and more efficient processing of authorization requests and the status of the authorization will be available immediately upon completion of its submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each prior authorization 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 and PET scans. To see the full list of imaging codes that require prior authorization, refer to the Prior Authorization 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 care professional).

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

Clinical Information

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

Prior Authorization

Molina collaborates with Evolent (formerly known as New Century Health) to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for Molina adult Members ages 18 and over.

All out-of-network Servicing Provider PA requests and PA requests for Molina Members under the age of 18 will be reviewed by Molina.

Evolent conducts reviews for the following professional services:

Cardiology

- Non-Invasive Cardiology
- Non-Invasive Vascular
- Cardiac Cath and Interventional Cardiology
- Vascular Radiology and Intervention
- Vascular Surgery
- Thoracic Surgery
- Cardiac Surgery
- Electrophysiology

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

For inpatient service requests, once approved by Evolent, the inpatient status will be reviewed by Molina upon notification of the admission. The inpatient admission and length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of hospitalization. Providers are to follow Molina's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time.

PA request submission

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

- For Providers' convenience, logging into the Evolent Provider Web Portal is the preferred submission method: my.newcenturyhealth.com
- Evolent's Provider Web Portal functionality offers instant approvals for PA requests
- Evolent Tel: (888) 999-7713, Option 1
- Evolent Fax intake: (877) 370-0963

Providers should call the Evolent Network Operations department at (888) 999-7713, Option 6, with questions or for assistance with access/training on the Evolent Provider Web Portal.

Molina requires prior authorization for specified services as long as the requirement complies with federal or state regulations and the Provider Agreement with Molina. The list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. To see the full list of codes that require prior authorization, please refer to the Prior Authorization LookUp Tool at MolinaMarketplace.com. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate and are posted on the Molina website at MolinaMarketplace.com.

CPT® is a registered trademark of the American Medical Association

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 Member ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and International Classification of Diseases 10th Revision (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 prior authorization.

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 psychological state, or in the opinion of the Provider with knowledge of the Member's medical or behavioral health condition, would subject the Member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

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 (855) 322-4077 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.

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 from the notification.

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

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

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

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

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement with Molina that requires Providers 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 prior authorization requests
- Receive notification of change in status of prior 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 (833) 322-1061.

Open Communication about Treatment

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

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

Delegated Utilization Management Functions

Molina may delegate UM functions to qualifying medical groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the **Delegation** section of this Provider Manual.

Communication and Availability to Members and Providers

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (855) 322-4077 during normal business hours, Monday through Friday (except for state and federal holidays) from 8 a.m. to 5 p.m. All staff members identify themselves by providing their first name, job title and organization.

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

After business hours, Providers can also utilize fax and the Availity portal for UM access.

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

Emergency Services

Emergency services means health care services needed to evaluate, stabilize or treat an emergency medical condition.

Emergency medical condition or emergency means the sudden onset of a medical, psychiatric or substance abuse condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably

be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily functions, or serious dysfunction of any bodily organ or part.

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

Emergency services are covered on a 24-hour basis without the need for prior authorization for all Members experiencing an emergency medical condition.

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition
2. Provided after the Member is stabilized
3. Provided to maintain the stabilized condition or under certain circumstances, to improve or resolve the Member's condition

Providers requesting an in-patient admission as a post stabilization service must request this type of service by contacting Molina at (855) 322-4077.

Inpatient admission requests (not including post-stabilization requests) received via fax will be processed within standard inpatient regulatory and contractual time frames

Molina also provides Members with a 24-hour Nurse Advice Line for medical advice. 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 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, unless the services are rendered in the limited circumstances delineated in M.C.L.A. 333.24507. Member payments to the non-participating facility will not apply to the Member's deductible or annual out-of-pocket maximum.

Care managers will contact Members identified as high utilizers of emergency services and provide outreach, assessment of utilization of emergency services and education to appropriate care and services to meet medical needs.

Inpatient Management

Planned Admissions

Molina requires prior authorization for all elective inpatient procedures to any facility. Facilities are required to notify Molina within 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 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 of the needed clinical documentation to support the inpatient admission may result in a denial of authorization for the inpatient stay.

If the admission does not meet medical necessity criteria for an inpatient setting, the facility may admit the Member to an observation setting. No authorization is required for observation. If the facility does not accept observation setting, the UM staff may request additional information and will forward the case for Medical Director review.

When would we contact you?

If additional clinical information is required.

If the need for additional medical services is identified post discharge, such as home health care or home infusion.

To notify you of our decisions:

- When services are approved, we will call or fax you with an authorization number and next review date.
- When services are not approved, we will attempt to call you. Written notification is also sent at the time of the decision giving you the reason for the denial. Member and provider appeal rights are included with the notification. If you would like a copy of the criteria that was used to make a denial determination, or you would like to discuss a denial decision with a Medical Director, please call (855) 322-4077.
- For urgent/emergent admissions, we will call or fax you the decision.
- If we are notified retrospectively of an admission and discharge, we will call or fax you.

Inpatient at time of Termination of Coverage

If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services.

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 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 the 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.

Concurrent Review/Discharge Planning/Continuity and Coordination of Care/Post-Hospital Discharge/ Managing Care Transition

Concurrent review is performed to determine medical necessity and appropriateness of a continued inpatient stay, to identify appropriate discharge planning needs, facilitate discharge to an appropriate setting in a timely manner and ensure continuity and coordination of the Member's care. Our staff collaborates with the physician, hospital discharge planning, practitioners and their representatives.

Concurrent reviews are conducted routinely as appropriate and medical necessity criteria is used as a guideline in performing review.

Readmissions

Readmission review is an important part of Molina's Quality Improvement (QI) 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 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 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 trauma, 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 prior authorization when required may result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error. In those cases, a medical necessity review will be performed. Decisions in this circumstance will be based on medical necessity.

Specific federal or state requirements or Provider contracts that prohibit administrative denials supersede this policy.

There are two (2) ways to request a retrospective authorization with an extenuating circumstance as described above.

Fax authorization request and clinical information (if required) to Health Care Services at (833) 322-1061.

Telephone (855) 322-4077

Please note if there is a denied Claim on file the Provider appeal process will need to be followed. For additional information please refer to the **Complaints, Grievance and Appeals Process section of this Provider Manual.

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 the appropriateness of care and the existence of coverage. Molina does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. Molina does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-Network Providers and Services

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

Avoiding Conflict of Interest

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

Molina does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina never provides financial incentives to encourage authorization decision

makers to make determinations that result in under-utilization. Molina also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

Molina HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Molina's Integrated Care Management (ICM) program via assessment or referral such as self-referral, 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 the 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

Molina's policy is 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 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 post-partum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4077.

Continuity and Coordination of Provider Communication

Molina stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including 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 themself, or unable to protect themself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

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

- Physicians, dentists, interns, residents or nurses
- Public or private school employees or childcare givers
- Psychologists, social workers, family protection workers or family protection specialists
- Attorneys, ministers or law enforcement officers

Suspected abuse and/or neglect should be reported as follows:

Child abuse

Michigan Department of Health and Human Services Children Protective Services Phone: (855) 444-3911

Adult abuse

Michigan Department of Health and Human Services Adult and Children Services Phone: (855) 444-3911

Molina's HCS teams will work with PCPs and medical groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/medical group/IPA, other delegated entities, or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Molina will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Molina will track, analyze and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper state agency.

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

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

- Assesses the Member to determine 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 plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of ICP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

Health Management

The tools and services described here are educational support for Molina Members and may be changed at any time as necessary to meet the needs of Molina Members. Level 1 Members can be engaged in the program for up to 30-90 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

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

- Living with Asthma
- Living with Diabetes
- Living with High Blood Pressure
- Living with Heart Failure (HF)
- Living with COPD
- Living with Depression
- Molina My Health – Weight Management
- Molina My Health – Tobacco Cessation
- Molina My Health – Nutrition

For more information about these programs, please call (833) 269-7830, or (TTY/TDD at 711 Relay). 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 Report Form (available at MolinaMarketplace.com/marketplace/mi/en-us/Providers/Provider-Forms within one (1) working day of the first prenatal visit and/or positive pregnancy test. The form should be faxed to Molina at (844) 861-1932.

Member Newsletters

Member newsletters are posted on the 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 mobile App.

Program Eligibility Criteria and Referral Source

Health management (HM) programs are designed for Molina Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach or other materials to access information on their condition. Members can contact the Molina Member Contact Center 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 Molina referrals from the 24-hour Nurse Advice Line, medication management or utilization management.
- Member self-referral due to general plan promotion of programs 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 Health Care 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 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 the Molina Member Contact Center.

Specialty Providers

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

Molina will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Molina UM department. Referrals to specialty care outside the network require prior authorization from Molina.

Care Management (CM)

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

The Molina care managers may be licensed professionals and are educated, trained, and experienced in Molina's ICM program. The ICM program is based on a Member advocacy philosophy, designed, and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes.

The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Molina case manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's ICP.

Referral to Care Management

Members with high-risk medical conditions and/or other care needs may be referred by their PCP, themselves, caregiver, discharge planner or Molina Healthcare Services to the ICM program. The case manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP, specialty Providers, ancillary Providers, the local health department, or other community-based resources when identified. The referral source should

be prepared to provide the care manager with demographic, health care, and social data about the Member being referred.

Members with the following conditions may qualify for care management and should be referred to the Molina ICM program for evaluation:

- High-risk pregnancy, including Members with a history of a previous preterm delivery.
- Catastrophic or end-stage medical conditions (e.g., neoplasm, organ/tissue transplants, End Stage Renal Disease).
- Comorbid chronic illnesses (e.g., asthma, diabetes, COPD, CHF, etc.).
- Preterm 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: (855) 322-4077
Fax: (248) 925-1732

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

Some behavioral health services may require prior authorization.

Behavioral health inpatient and residential services can be requested by submitting a prior authorization form or contacting Molina's prior authorization team at (855) 322-4077. Providers requesting after-hours authorization for these services should utilize Availity 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 the Diagnostic and Statistical Manual of Mental Disorders (DSM) classification. Molina utilizes standard, generally accepted medical necessity criteria for prior authorization reviews.

For additional information please refer to 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 referred to an in-network behavioral health Provider via referral from a PCP, medical specialist or by Member self-referral. PCPs are able to screen and assess Members for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. 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 self-refer or be referred to a PCP, specialist or behavioral health Provider. However, individual services provided by non-network behavioral health Providers will require prior authorization.

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

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) calendar days of the discharge date.

Interdisciplinary Care Coordination

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

Care Management

Molina's care management team includes licensed nurses and clinicians with behavioral health experience to support Members with mental health and/or substance use disorder (SUD) needs. Members with high-risk psychiatric, medical or psychosocial needs may be referred by a behavioral health professional or primary care provider to the ICM program.

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

Phone: (855) 322-4077
Fax: (248) 925-1732

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 an 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 refer to the **Quality** section of this Provider Manual for specific access to appointment details.

All Members receiving inpatient psychiatric services must be scheduled for a psychiatric outpatient appointment prior to discharge. The aftercare outpatient appointment must include the specific time, date, location and name of the Provider. This appointment must occur within seven (7) days of the discharge date. If a Member misses a behavioral health appointment, the behavioral health Provider shall contact the Member within 24 hours of a missed appointment to reschedule.

Behavioral Health Crisis Lines

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 with concerns about someone else can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

Behavioral Health Tool Kit for Providers

Molina has developed an online Behavioral Health Tool Kit to provide support with screening, assessment and diagnosis of common behavioral health conditions, plus access to behavioral health HEDIS® tip sheets and other evidence-based guidance, training opportunities for Providers and recommendations for coordinating care. The material within this tool kit is applicable to Providers in both medical and behavioral health settings. The Behavioral Health Tool Kit for Providers can be found under the “Health Resources” tab on the MolinaMarketplace.com Provider website.

10. Quality

Maintaining Quality Improvement Processes and Programs

Molina works with Members and Providers to maintain a comprehensive Quality Improvement (QI) program. You can contact the Molina Quality department at (888) 898-7969.

The address for mail requests is:

Molina Healthcare of Michigan, Inc.
Quality Department
880 W. Long Lake Road
Troy, MI 48098

This Provider Manual contains excerpts from the Molina QI program. For a complete copy of Molina's QI program, you can contact your Provider Relations representative or call the telephone number above to receive a written copy.

Molina has established a QI program that complies with regulatory requirements and accreditation standards. The QI program provides structure and outlines specific activities designed to improve the care, service and health of our Members. In our QI program description, we describe our program governance, scope, goals, measurable objectives, structure and responsibilities.

Molina does not delegate quality improvement activities to medical groups/IPAs. However, Molina requires contracted medical groups/IPAs to comply with the following core elements and standards of care. Molina medical groups/IPAs must:

- Have a quality improvement program in place.
- Comply with and participate in Molina's QI program including reporting of access and availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations.
- Cooperate with Molina's quality improvement activities that are designed to improve quality of care and services and Member experience.
- Allow Molina to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their PCPs. Molina continues to support safe health practices for our Members through our safety program, pharmaceutical management and care management/health management programs and education.

Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA) and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has established a systematic process to identify, investigate, review and report any quality of care, adverse event/never event, critical incident (as applicable), and/or service issues affecting Member care. Molina will research, resolve, track and trend issues. Confirmed adverse events/never events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

Molina is not required to pay for inpatient care related to "never events."

Medical Records

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

- Medical record confidentiality and release of medical records within medical and 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 Member medical records:

- Each patient has a separate medical record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available during each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the record dictates.

- If electronic, all those with access have individual passwords.
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language, and sexual orientation and gender identity.
- Storage maintenance for the determined timeline and disposal 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 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 reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physicals and operative report.
- Labor and delivery record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

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

Retrieval

- The medical record is available to the Provider at each encounter.
- The medical record is available to Molina for purposes of quality improvement.
- The medical record is available to the applicable state and/or federal agency and the external quality review organization upon request
- The medical record is available to the Member upon their request.
- A storage system for inactive Member medical records which allows retrieval within 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.
- Medical records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training all staff on handling and maintaining protected health care information.
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity and social determinants of health is protected.

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

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents**.**

Advance directives are a written choice for health care. There are two (2) types of advance directives:

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

When there is no advance directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Members18 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 the Molina Member Contact Center or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

Molina network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Molina will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS regulations gives 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 directive instructions.

Molina will notify the Provider of an individual Member's advance directive 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 directive forms are state-specific to meet state regulations.

Molina expects that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine, and pediatric), OB/GYN (high-volume specialists), Oncologist (high-impact specialists) and behavioral health Providers. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted.

The access standards below are based on standards outlined per contract.

Medical Appointment

Visit type	Standard wait times
Office Wait Time	Not to Exceed 45 Minutes
Routine, asymptomatic	Within 30 business days of request
Routine, symptomatic	Within 30 business days of request

Visit type	Standard wait times
Urgent Care	Within 24 hours
After Hours Care	24 hours/day; 7 days/week
Specialty Care	Within 45 days of request
Urgent Specialty Care	Within 24 hours

Mental/Behavioral Health

Visit Type	Standard Wait Times
Life-Threatening Emergency	Immediately
Non-life-Threatening Emergency	Within 6 hours of the request.
Urgent Care	Within 24 hours of the request.
Routine Care	Within 10 business days of the request.
Follow-up Routine Care	Within 10 calendar days of request

Additionally, Providers should:

- Call patients 48 hours before their appointments to remind them about their appointments and anything they will need to bring.
- Consider offering evening and/or weekend appointments.
- Provide clear instructions on how to access care after office hours.

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

Office Wait Time

For scheduled appointments, the wait time in offices should not exceed 45 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After Hours

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

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 obstetrical and gynecologic services is monitored to ensure Members have direct access to participating Providers for

obstetric and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available from your local Molina Quality department.

Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement and Health Equity Transformation Committee on an annual basis.

Provider network adherence to access standards is monitored via one (1) 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 Health Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Health Equity Transformation Committee.

Quality of Provider Office Sites

Molina Providers are to maintain office-site and medical record keeping practices standards. Molina continually monitors Member complaints and appeals/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space

Physical Accessibility

Molina evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building,

accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

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

Adequacy of Waiting and Examining Room Space

During the site visit as required, Molina assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members.

The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR-certified employee is available.
- Yearly Occupational Safety and Health Administration (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 Clinical Laboratory Improvement Amendment (CLIA) waiver is displayed when the appropriate lab work is run in the office.

- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Services to Enrollees Under 21 Years of Age

Molina maintains systematic and robust monitoring mechanisms to ensure all preventive services necessary for Enrollees under 21 years of age are timely according to required preventive health guidelines. All Enrollees under 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 that the Provider submits a written CAP to Molina within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active QI program. The QI program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. Molina focuses on reducing health care disparities through the QI program. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management and Care Management

The Molina health management and care management programs provide for the identification, assessment, stratification and implementation of appropriate interventions for Members with chronic diseases.

For additional information please refer to the Health 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 CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)

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

All CPGs 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. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, CPGs are distributed to Providers at MolinaMarketplace.com and the Provider Manual. Notification of the availability of the CPGs is published in the Molina Provider newsletter.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) Bright Futures/American Academy of Pediatrics and Centers for Disease Control and Prevention (CDC), in accordance with 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 CDC. 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 CDC. 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 Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, preventive health guidelines are distributed to Providers at MolinaMarketplace.com 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:

- 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 Agreement with Molina. The use of performance data may include, but is not limited to, the following:

(1) Development of quality improvement activities
(2) Public reporting to consumers
(3) Preferred status designation in the network
(4) 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.

HEDIS®

Molina utilizes 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 Experience 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 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 Experience 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 QHP Enrollee Experience Survey both focus on Member experience with health care Providers and health plans, Molina conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Molina, as this is one of the primary methods, used to identify improvement areas pertaining to the Molina Provider network. The survey results have helped establish improvement activities relating to Molina's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Molina monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Molina also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

Quality Rating System (QRS) for Marketplace

Based on Section 1311(c)(3) of the Affordable Care Act, CMS developed the 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 to 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 are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and QHP Enrollee Experience Survey Star Ratings measures, contact your local Molina Quality department.

11. Risk Adjustment Management Program

What is Risk Adjustment?

CMS defines risk adjustment as a process that helps to 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 care for our Members based on their health care needs. Risk adjustment considers numerous clinical data elements of a Member's health profile to determine 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 our Members
- Have the resources to deliver the highest quality of care to Molina Members

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Molina Members by using one of the automated methods available and supported by Provider's electronic medical records (EMR), including but not limited to Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The CDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

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

The Provider will participate in Molina's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the 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 a Direct Address, Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the 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.

Risk Adjustment Data Validation (RADV) Audits

As part of the regulatory process, federal agencies may conduct 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.

Your Role as a Provider

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

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

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

Contact Information

For questions about Molina's risk adjustment programs, please contact your Molina 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 plan also addresses fraud, waste and abuse prevention, detection and correction along with and 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 costs 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.

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 AKS statutes and regulations and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

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

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

Marketing guidelines and requirements

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

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

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

Stark Statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare 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

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

Definitions

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

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

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

Examples of Fraud, Waste, and Abuse by a Provider

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

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.

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

Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider Claims and Claims System

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

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

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

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

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with Molina 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 with Molina or at law or equity.

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

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

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

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from Molina, the Provider is required to allow Molina to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy laws.

Claim Auditing

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

The Provider acknowledges Molina's right to conduct pre and post-payment billing audits. The Provider shall cooperate with Molina's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claim information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure

to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.

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

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

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

Provider Education

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

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

Reporting Fraud, Waste, and Abuse

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

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

Fraud, waste or abuse cases may also be reported to Molina's Compliance department anonymously without fear of retaliation.

Molina Healthcare of Michigan, Inc.
Attn: Compliance
880 W. Long Lake Road
Troy, MI 48098

The following information must be included when reporting:

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

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

Michigan Department of Health and Human Services
Office of Inspector General
P.O. Box 30062
Lansing, MI 48909

Phone: (855) MI-FRAUD

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

Phone: 1-800-MEDICARE (1-800-633-4227)

or

Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Phone: (800) 447-8477
TTY/TDD: (800) 377-4950
Fax (10 page max): (800) 223-8164

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

HIPAA Requirements and Information

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

Molina expects that its contracted Providers will respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member PHI. Molina provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Molina uses and discloses their PHI and includes a summary of how Molina safeguards their PHI.

Telehealth/telemedicine providers: telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law including:

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

Applicable Laws

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

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

2. **State Medical Privacy Laws and Regulations**.

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

Artificial Intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a

denial, delay, reduction, or modification of covered services to Molina Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician.

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

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

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law.

Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."
2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
    - Quality improvement
    - Disease management
    - Case management and care coordination

[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

- Training programs
- Accreditation, licensing and credentialing

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

Confidentiality of Substance Use Disorder Patient Records

Federal confidentiality of substance use disorder patient records regulations 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 patient records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Molina may, on occasion, inadvertently misdirect or disclose PHI pertaining to Molina Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Molina Members in order to protect their privacy.

The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of Molina.

Written Authorizations

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

Patient Rights

Patients are afforded various rights under HIPAA. 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.

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
- Claim 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 NPI rule promulgated under HIPAA. The Provider must obtain an NPI from NPPES for itself or for any subparts of the Provider.

The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and utilization management activities are the "business associates" of Molina. Under HIPAA, Molina must obtain contractual assurances from all business associates that they will safeguard Member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's privacy and security rules.

Reimbursement for Copies of PHI

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

- Utilization management
- Care coordination and/or complex medical care management services

- Claim review
- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records

Information Security and Cybersecurity

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

1. Definitions:

   (a) "Molina Information" means any information: (i) provided by Molina to Provider; (ii) accessed by Provider or available to Provider on Molina's Information Systems; or (iii) any information with respect to Molina or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Molina Nonpublic Information.

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

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

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

   (e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security

breach and incident reporting requirements, all as amended or updated from time to time, and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

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

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

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

(h) "Nonpublic Information" includes:
i. Molina's proprietary and/or confidential information;
ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information", "personal data", "personally identifiable information", "personal information" or any other similar term as defined pursuant to any applicable law; and
iii. Protected Health Information as defined under HIPAA and HITECH.

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

administrative, technical, and physical safeguards pursuant to HIPAA, HITECH, and other applicable U.S. federal, state, and local laws.

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

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

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

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

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

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

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. Provider agrees that any and all Molina Information will be stored, processed, and maintained solely on designated target servers or cloud resources. No Molina Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. Provider agrees to store all Molina Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Molina Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Molina and/or any other parties expressly designated by Molina shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. Provider agrees that any and all Molina Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement and this section. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Molina Information or data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Molina.

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

(a) Resilience Questionnaire. Provider shall complete a questionnaire provided by Molina to establish Provider's resilience capabilities.

(b) BC/DR Plan.

(i) Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and Molina. The BC/DR Plan shall include the following:

a) Notification, escalation and declaration procedures.
b) Roles, responsibilities and contact lists.
c) All Information Systems that support services provided to Molina.

d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to Molina.

e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.

f) Detailed list of resources to recover services to Molina including but not limited to: applications, systems, vital records, locations, personnel, vendors, and other dependencies.

g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.

h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to Molina. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

(ii) To the extent that Molina Information is held by 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 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 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve Molina Information, Provider shall notify Molina's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve Molina Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment, and evidence of all due diligence and sanctions checks performed in compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to Molina's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Phone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com
Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at Molina's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by Molina, (ii) fully cooperate with Molina to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers, and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law), and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving Molina Information without the prior written consent of Molina.

(e) Following notification of a Cybersecurity Event, Provider must promptly provide Molina any documentation requested by Molina to complete an investigation,

or, upon request by Molina, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;
ii. assess the nature and scope of the Cybersecurity Event;
iii. identify Molina's Information that may have been involved in the Cybersecurity Event; and
iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release, or use of Molina Information.

(f) Provider must provide Molina the following required information regarding a Cybersecurity Event in electronic form. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Molina concerning the Cybersecurity Event. The information provided to Molina must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;
ii. a description of how the information was exposed, lost, stolen, or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen, or breached information has been recovered and if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information, or types of information allowing identification of the consumer;
viii. the period during which the Information System was compromised by the Cybersecurity Event;
ix. the number of total consumers in each State affected by the Cybersecurity Event;
x. the results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;
xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by Molina, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of Provider.

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

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Molina and/or any designated representative or vendor of Molina. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Molina performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Provider Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Molina's due diligence/security risk assessment questionnaire; (ii) agrees to inform Molina promptly of any material variation in operations from what was provided in Provider's response to Molina's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to Molina's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. Other Provisions. 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.

13. Claims and Compensation

Payer ID	**38334**
Availity portal	**provider.MolinaHealthcare.com**
Clean Claim Timely Filing	**365 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 Claim 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 Claim submission options:

- Submit Claims directly to Molina via the Availity portal
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 38334

Availity Portal

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 Claim status
- View ERA and EOP
- Create and manage Claim templates
- Create and submit a Claim appeal with attached files

Clearinghouse

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

If you do not have a clearinghouse, Molina offers additional electronic Claims submissions options as shown by logging on to the Availity 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 Claim 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

Providers shall promptly submit to Molina Claims for covered services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and shall include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 365 calendar days after the discharge for inpatient services or the date of service for outpatient services. Any Claims for covered services rendered in accordance with the circumstances delineated in M.C.L.A. 333.24507 must be submitted by the out-of-network Provider to Molina within 60 calendar days after the discharge for inpatient services or the date of service for outpatient services, or otherwise in accordance with M.C.L.A. 333.24511 or M.C.L.A. 333.24513.

If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within 60 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 American National Standards Institute (ANSI) X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number 38334. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim submission instructions on the Molina Member 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 30 calendar days from the change. Molina supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Molina may validate the NPI submitted in a Claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website at MolinaMarketplace.com 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 with Strategic National Implementation Process (SNIP) levels 1 to 5.

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

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided

- Valid Diagnosis Pointers
- Total billed charges
- Place and type of service code
- Days or units as applicable (anesthesia Claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- 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), NDC Units, Units of Measure and Days or Units 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 Claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

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

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized ASC X12N 837 formats. Electronic Claims are validated for compliance with 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 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 Michigan, Inc.
P.O. Box 22668
Long Beach, CA 90801

When submitting paper Claims:

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

*(*Please **do not** submit Claims to the Troy, Michigan address as your Claim may be returned.)*

Faxed Claims are not accepted by Molina and if received, the Claim will be returned.

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.

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

Corrected Claims must be sent within 365 calendar days from the date of service or within 90 days of the most adjudicated Claim.

Corrected Claim 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 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 30 months after becoming eligible for Medicare. After the 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 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, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
10.) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Bypass

b) Gastroenterostomy
c) Laparoscopic Gastric Restrictive Surgery

11.) Surgical Site Infection Following Certain Orthopedic Procedures:
a) Spine
b) Neck
c) Shoulder
d) Elbow

12.) Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)

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

14.) Iatrogenic Pneumothorax with Venous Catheterization

What this means to Providers

- Acute Inpatient Prospective Payment System (IPPS) hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

For additional information on the Medicare HAC/POA program, including billing requirements, please refer to the CMS site 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 International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes.

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 Claim 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 CMS, including:
  - 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.
- 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.

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 located at MolinaMarketplace.com/marketplace/mi/en-us/Providers/Policies/benefit-interpretation-policies.

National Correct Coding Initiative (NCCI)

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

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

circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

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

CPT and HCPCS Codes

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

Modifiers

Modifiers consist of two (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 ICD-10-CM and ICD-10-PCS billing rules and will deny Claims that do not meet Molina's ICD-10 Claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

POS code are two (2)-digit codes placed on health care professional claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS code should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Type of Bill

Type of bill is a four (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 (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (DRG)

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

Molina processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Molina-assigned DRG will take precedence.

Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

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

Providers will need to submit Claims with both HCPCS and NDC codes with the exact NDC number that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx)

as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three (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 ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

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

Claim Auditing

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

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

In reviewing medical records for a procedure, Molina reserves the right, and where unprohibited by regulation, to select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Molina

paid in error. The estimated proportion, or error rate, may be extrapolated across all Claims to determine the amount of overpayment.

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

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

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with Molina.

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 30 to 45 days after receipt of Clean Claims. Molina will process any Claims for services rendered by out-of-network Providers in the limited circumstances in M.C.L.A. 333.24507 in accordance with that provision and within 60 days after receipt of Clean Claims and the out-of-network Provider may not collect or attempt to collect from the Member any amount other than the applicable in-network coinsurance, copayment or deductible.

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 EFT and 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 the Molina Provider Contact Center.

Overpayments and Incorrect Payments Refund Requests

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

If, 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 by adjusting the Claim.

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

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

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

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

Claim Disputes/Reconsiderations/Appeals

Information on Claim disputes/reconsiderations/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.

Encounter Data

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

Encounter data must be submitted at least once per month and within 365 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. Data must be submitted with Claims level detail for all non-institutional services provided.

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

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

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

When Encounters are filed electronically Providers should receive two (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

Provider Claims Dispute

The processing, payment or nonpayment of a Claim by Molina shall be classified as a Provider Dispute and shall be sent electronically via the Availity portal or via fax at (248) 925-1768 using the Claim Dispute Request Form.

Claim Dispute Request Form

The Claims Dispute Request Form is available on the Molina website at MolinaMarketplace.com/marketplace/mi/en-us/Providers/~/media/Molina/PublicWebsite/PDF/providers/common/Michigan/Claim-DisputeAppeal-RequestForm.pdf.

Timely Filing Appeal/Disputes

Timely filing disputes must be submitted with supporting documentation showing extenuating circumstances for not submitting the Claim within standard timely filing limit. If Claim was billed to another payer, please include the submission date and denial date by the other payer. For retro enrollment Claims, include the date the Members eligibility was updated to Molina.

Code Edit Appeal/Disputes (Correct Coding Initiative Edits)

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

Coordination of Benefits (COB) Disputes

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

Provider Appeals

For Provider appeals, Providers have the right to appeal any denial decision made by Molina.

Any denied Claim for a service that requires authorization is considered a post-service appeal. Our appeal process is objective, thorough, fair and timely. Provider appeals shall be sent electronically via the Availity portal or via fax at (248) 925-1768.

If unable to submit electronically appeals may be sent to the following address:

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

Pre-service

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

In the event an authorization has been denied, Providers may submit an appeal on behalf of the Member (with written approval to act as a designated representative) within 60 calendar days of the denial, prior to the service being completed. The Provider may serve as designated representative for the Member and act on their behalf (hereafter referred to as "representative"). The representative can be a friend, a family member, health care Provider or an attorney. An Authorized Representative Form can be found on Molina's Member website at MolinaMarketplace.com/marketplace/mi/en-us/Providers/~/media/Molina/PublicWebsite/PDF/providers/common/Michigan/AOR-Form.pdf.

In the event of an inpatient admission authorization denial, Providers may submit additional medical records and request a continued stay review by contacting Molina at (855) 322-4077.

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

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

Once the service or procedure has occurred or the Member has been discharged from the facility, the Provider must utilize the described post-service process in order to appeal.

Retro Authorization

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

Retrospective authorization is not a Molina process, except in the event of extenuating circumstances. An extenuating circumstance is defined as: Provider could not have known that patient was a Molina Member at the time the service was rendered. Provider did not know nor reasonably could have known that patient needed a service that required authorization prior to the service being rendered.

Documentation to demonstrate extenuating circumstances must be submitted at the time of the request. All requests for retrospective authorization with an extenuating

circumstance must be received within ten (10) calendar days of becoming aware of the extenuating circumstance. Determinations, in this circumstance, will be based on medical necessity guidelines and UM policies and criteria.

There are two (2) ways to request a retrospective authorization with extenuating circumstance.

1) Fax authorization request, clinical information (if required) and documentation demonstrating extenuating circumstance to Health Care Services at (833) 322-1061.
2) By phone at (855) 322-4077.

Please note if there is a denied Claim on file the Post-Service Appeal process noted below will need to be followed.

Post-Service Appeal*

*Post-service is considered an appeal of any adverse determination after rendering a service or procedure. There are two (2) types of post service Provider appeals:

1) Administrative decisions
2) Medical necessity review

Administrative Denials

Molina has a one (1) level appeal process for the Practitioner/Provider appeal of post-service administrative denials. An **example of an administrative denial** is failure to authorize services according to required timeframes. Retrospective authorization is not a Molina process, except in the event of extenuating circumstances. If a clean Claim has not been submitted and an extenuating circumstance exists, these requests should follow the **Health Care Services** section of this Provider Manual.

Level 1

A. The appeal must include **NEW** supporting evidence and/or documentation justifying the service, care or treatment being appealed and reason for notification outside of Molina notification timeframes. Portions of the medical record may be submitted.
    a. Reason Authorization was not obtained
    b. History and Physical
    c. Consultations
    d. Physician Progress Notes
    e. Laboratory Results
    f. Radiology Results
    g. Emergency Department Summary
    h. Physician Discharge Summary
    i. Leaving Against Medical Advice information

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

Medical Necessity Denials

Molina has a two (2) level appeal process for the Practitioner/Provider appeal of post-service medical necessity denials. An **example of medical necessity denials** are inpatient admissions which did not meet medical necessity criteria guidelines.

Level 1

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

Level 2

A. If you disagree with the Level 1 appeal decision, a Practitioner must submit a second level written appeal within 90 calendar days of the date of the Level 1 denial notice. The request **must** clearly state it is for a Level 2 review.

B. The written Level 2 appeal request must include **additional** supporting documentation not previously submitted with the Level 1 appeal, or it will be dismissed as same as Level 1. Some examples of additional supporting documentation include:
   a. A rebuttal to Molina's Level 1 appeal denial rationale
   b. How the Member met InterQual acute care criteria
   c. Clinical documentation (i.e., chart notes)

C. The appeal will/may be reviewed by a Medical Director or by a consultant of same or similar specialty.

D. The Medical Director will render a decision and written notification will be provided within 30 calendar days of the receipt of a post-service appeal.

Request for Binding Arbitration

A request for arbitration may be submitted in writing to Molina's Provider Inquiry Research and Resolution department after all Molina appeal processes have been exhausted. Arbitration must be initiated within one (1) year of the date of service or an extenuating circumstance; otherwise it shall be deemed waived.

Molina's Legal department will coordinate the binding arbitration process in accordance with the American Arbitration Association rules for Arbitration for **Non-Contracted** providers, and pursuant to the provisions of the Provider Agreement with Molina for Contracted Providers.

Arbitration disputes will be processed in a timely and efficient manner with adherence to state/federal regulations.

Send all written requests for arbitration to:

Molina Healthcare of Michigan, Inc.
Attn: Appeals and Grievances (Arbitration)
880 West Long Lake Rd., Suite 600
Troy, MI 48098

Rapid Dispute Resolution

Molina supports the Michigan Department of Health and Human Services (MDHHS) Rapid Dispute Resolution Process (RDRP) for hospitals under the MDHHS Access Agreement that **DO NOT** actively contract with the plan.

The purpose of this policy and procedure is to ensure Provider disputes are processed in a timely and efficient manner with adherence to state/federal regulations. Provider disputes will be reviewed to determine the appropriate resolution.

Send all written requests for rapid dispute resolution to:

Molina Healthcare of Michigan, Inc.

Attn: Provider Appeals (RDRP)
880 West Long Lake Rd., Suite 600
Troy, MI 48098

Grievances and Complaints

If a Member has a problem with any Molina service, the Member can call any of the following toll-free numbers for help:

- Call Molina toll-free at (888) 560-4087, Monday through Friday, 8 to 5 p.m., Eastern time.
- Deaf or hard of hearing Members may call our toll-free TTY/TDD number at (888) 665-4629. Members may also contact us by calling the Telecommunications Relay Service at 711 for deaf or hard of hearing.
- Members may also send Molina grievances and/or complaints in writing by mail or by filing online at our website. Our address is:

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

Types of Grievances

There are two (2) types of grievances:

1. An administrative grievance is a complaint or dissatisfaction a Member has with a Molina decision relating to the availability, delivery, or quality of health care services.
2. An Adverse Benefit Determination grievance is one where the Member disagrees with an Adverse Benefit Determination made by Molina.

The process for addressing a grievance depends on the type of grievance. The subsection immediately below describes the Administrative Grievance Process. A description of the Adverse Benefit Determination Grievance and Appeal Process is described later in this section.

For purposes of the "Administrative Grievance Process," "Adverse Benefit Determination Grievance and Appeal Process," and "External Review Process" portions of this section, the term "Member" shall include the Member and the Member's authorized representative.

Administrative Grievance Process

The Member may submit their administrative grievance to Molina by:

- Sending Molina an administrative grievance in writing by mail. Our address is:

  Molina Healthcare of Michigan, Inc.
  Attention: Member Grievances and Appeals

PO Box 182273
Chattanooga, TN 37422

Molina will send the Member a letter acknowledging receipt of the grievance within five (5) calendar days and will then issue a formal response within 30 calendar days for pre-service and 60 calendar days for post-service of the date of the initial contact with Molina.

If the Member is not satisfied with Molina's response to the administrative grievance, the Member may file an appeal with Molina if Molina can receive it and process it within 60 calendar days of the initial receipt of the administrative grievance. Molina will send the Member a letter acknowledging receipt of the appeal within five (5) calendar days. Molina complete all levels of the grievances and appeal procedures within 60 calendar days.

Molina may extend this period by up to ten (10) business days if Molina has requested and not received information from the Member's Provider and the Member agrees.

The Member must file grievances within 180 days from the day the incident or action occurred. If the administrative grievance involves an imminent and serious threat to the Member's health, Molina will quickly review the administrative grievance. Examples of imminent and serious threats include, but are not limited to, severe pain, potential loss of life, limb, or major bodily function. Molina will issue a formal response no later than 72 hours. Within ten (10) days after receipt of formal response, the Member may request a review of the grievance from the Michigan Department of Insurance and Financial Services.

Adverse Benefit Determination Grievance and Appeal Process

Definitions

The capitalized terms used in this appeals section have the following definitions:

The term "**Adverse Benefit Determination**" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

The denial of payment for services or charges (in whole or in part) pursuant to Molina's contracts with Participating Providers, where the Member is not liable for such services or charges, are not Adverse Benefit Determinations.

"**Authorized Representative**" means an individual authorized in writing by the Member or State Law to act on the Member's behalf in requesting a health care service, obtaining claim payment, or during the internal appeal process. A health care provider may act on behalf of the Member without the Member's express consent when it involves an Urgent Care Service.

"**Final Adverse Benefit Determination**" means an Adverse Benefit Determination that is upheld after the internal appeal process. If the period allowed for the internal appeal elapses without a determination by Molina, then the internal appeal is a Final Adverse Benefit Determination.

"**Post-Service Claim**" means we rendered an Adverse Benefit Determination for a service that completed.

"**Pre-Service Claim**" means Molina rendered an Adverse Benefit Determination and the requested service did not complete.

"**Urgent Care Services Claim**" means we rendered an Adverse Benefit Determination and the requested service did not complete, where the application of non-urgent care appeal periods could seriously jeopardize:

- The Member's life or health or the Member's unborn child; or,
- In the opinion of the treating physician, would subject the Member to severe pain unless the Member receives the care or treatment that is the subject of the Claim.

Internal Appeal

The Member or Member's Authorized Representative, or a treating Provider or facility may submit an appeal of an Adverse Benefit Determination. Molina will provide the Member with the forms necessary to initiate an appeal.

The Member may request these forms by contacting Molina at the telephone number listed on the Molina Member ID card. While Member's are not required to use Molina's pre-printed form, Molina strongly encourages Members to do so to facilitate logging, identification, processing, and tracking of the appeal through the review process.

Members may also request the clinical review criteria used to determine Medical Necessity in their particular situation by contacting the Grievances and Appeals Coordinator at (888) 560-4087.

If a Member need assistance in preparing the appeal, or in submitting an appeal verbally, the Member may contact Molina for such assistance at this address:

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

Phone: (888) 560-4087

If the Member is hearing impaired, they may also contact Molina via the Telecommunications Relay Service at 711.

The Member or the Member's Authorized Representatives must file an appeal within 180 days from the date of the notice of Adverse Benefit Determination. Within five (5) business days of receiving an appeal, Molina will send the Member or Authorized Representative a letter acknowledging receipt of the appeal.

Personnel who were not involved in the making of the Adverse Benefit Determination will review the appeal. The review will include input from health care professionals in the same or similar specialty as typically manages the type of medical service under review.

Timeframe for Responding to Appeal

Request Types	Timeframe for Decision
Urgent Care Service	Within 72 hours.
Pre-service Authorization	Within 30 days.
Concurrent Service (a request to extend or a decision to reduce a previously approved course of treatment)	Within 72 hours for Urgent Care Services and 30 days for other services.
Post-Service Authorization	Within 60 days.

Exhaustion of Process

The foregoing procedures and process are mandatory and must be exhausted prior to establishing litigation or arbitration or any administrative proceeding regarding matters within the scope of this section.

General Rules and Information

General rules regarding Molina's Grievance and Appeal Process include the following:

- Members must cooperate fully with Molina in the effort to promptly review and resolve a complaint or appeal. In the event the Member does not fully cooperate with Molina, Molina will deem the Member to have waived their right to have the Complaint or Appeal processed within the periods set forth above.
- Molina will offer to meet with the Member by telephone. Molina will make appropriate arrangements to allow telephone conferencing at our administrative offices. Molina will make these telephone arrangements with no additional charge to the Member.
- During the review process, Molina will review the services in question without regard to the decision reached in the initial determination.
- Molina will provide the Member with new or additional informational evidence that it considers, relies upon, or generates in connection with an appeal that was not available when we made the initial Adverse Benefit Determination. A "full and fair" review process requires Molina to send any new medical information to review directly so the Member has an opportunity to review the Claim file.

Telephone Numbers and Addresses

Members may contact a Molina Grievances and Appeals Coordinator at the number listed on the acknowledgement letter or notice of Adverse Benefit Determination or Final Adverse Benefit Determination. Below is a list of phone numbers and addresses for grievances and appeals.

General Contact Information

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
PO Box 30220
Lansing, MI 48909-7720

Online: michigan.gov/difs

Phone: (877) 999-6442
Fax: (517) 284-8838

Molina Healthcare of Michigan, Inc.
PO Box 182273
Chattanooga, TN 37422

Phone: (888) 560-4087

Delivery service

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan St., 7th floor
Lansing, MI 48933-1521

External Review Process

Members may request an external review of an Adverse Benefit Determination from the Michigan Department of Insurance and Financial Services only after exhausting the Molina internal review process described above unless:

1. Molina agrees to waive our internal review process
2. Molina has not complied with the requirements of our internal review process
3. The Member requests an expedited external review at the same time the Member requests an expedited internal review

How to File an External Review Request

The Member must file a request with the Michigan Department of Insurance and Financial Services for an external review (sometimes also referred to as "independent review") of an Adverse Benefit Determination no later than sixty (60) days after the Member receives the Final Adverse Benefit Determination notice from Molina.

The Member must use the Health Care Request for External Review form to file the request that is available from either Molina's Customer Support Center at (888) 560-4087 or write to:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909

Phone: (877) 999-6442

Online: michigan.gov/difs

The external review request must contain an authorization for the necessary parties to obtain medical records for purposes of making a decision on the external review request.

The external review decision is binding on Molina and the Member except to the extent that other remedies are available under federal and state laws.

Standard External Review

Within five (5) business days of receiving the Health Care Request for External Review form, the Director of the Department of Insurance and Financial Services (DIFS) will complete a preliminary review of the request to determine whether:

- The individual was a Member at the time of rescission, or the health care service was requested or provided;
- The health care service that is the subject of the Adverse Benefit Determination is reasonably a covered service;
- The Member has exhausted Molina external review process described above;
- The Member has provided all the information and forms required for the external review; and,
- The Adverse Benefit Determination involves issues of Medical Necessity or clinical review.

If the request is not complete, the Director of DIFS will inform the Member what information or materials are needed to make the request complete.

If the request is not eligible for external review, the Director of DIFS will inform the Member in writing of the reasons why the request is not eligible for external review.

If a request is eligible for external review, the Director of DIFS will:

- Notify Molina of acceptance of the request for external review of an Adverse Benefit Determination; and,
- Notify the Member that the request has been accepted and that the Member may submit additional information within seven (7) business days of receipt of the Director of DIFS's notice.

If the Director of DIFS determines that the Adverse Benefit Determination involves an issue of Medical Necessity or clinical review criteria, the Director of DIFS will assign the request for external review to an approved independent review organization.

If the Adverse Benefit Determination does not involve issues of Medical Necessity or clinical review criteria, the Director of DIFS will conduct the review.

The independent review organization will provide its written recommendation to uphold or reverse the Adverse Benefit Determination to the Director of DIFS not later than 14 days after being assigned the request to review the Adverse Benefit Determination.

The Director of DIFS will notify the Member and Molina of their decision to uphold or reverse the Adverse Benefit Decision within seven (7) business days after receiving the external review organizations recommendation.

If the Director of DIFS conducts the review of the Adverse Benefit Determination because it does not involve issues of Medical Necessity or clinical review criteria, the Director of DIFS will notify the Member and Molina of their decision within 14 business days after they make the decision to conduct the review. If the Adverse Benefit Determination is reversed, Molina will immediately approve the coverage that was the subject of the Adverse Benefit Determination and process any benefit that is due.

Expedited External Review Requests

Members may request an expedited external review when:

- The Adverse Benefit Determination involves a medical condition that would seriously jeopardize the life and health of the Member or jeopardize the Member's ability to regain maximum function;
- The Member has filed a request for expedited internal review of the Adverse Benefit Determination with Molina as described above; and,
- The Member makes the request for an expedited external review within ten (10) days of receiving the Adverse Benefit Determination.

Upon receipt of the Health Care Request for External Review form, the Director of DIFS will immediately send a copy of the request to Molina.

If the Director of DIFS determines that the request to review an Adverse Benefit Determination involves an issue of Medical Necessity or clinical review criteria, they will assign the request for an expedited review to an independent review organization.

The independent review organization will decide immediately whether the Member will be required to first complete the expedited internal review process.

If the independent review organization determines that the Member must complete the expedited internal review process it will immediately notify the Member.

The independent review organization will provide its recommendation of whether to uphold or reverse the Advance Benefit Determination as soon as expeditiously as the Member's medical condition or circumstances require, but in no event more than 36 hours after the date the Director of DIFS received the request for an expedited external review.

As expeditiously as the Member's medical condition or circumstances require, but in no event more than 24 hours after receiving the independent review organization's recommendation, the Director of DIFS will notify the Member and Molina of the decision to uphold or reverse the Adverse Benefit Determination. If the notice is not in writing, the Director of DIFS will provide written confirmation of the decision to the Member and Molina within two (2) days after providing the original notice of their decision.

Reporting

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

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 NCQA. The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

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

Types of Practitioners Credentialed & Recredentialed

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

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- 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

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 documentation provided by Molina.

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

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

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

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

- **License, Certification or Registration** –Practitioners must hold a current and valid license, certification or registration to practice in their specialty in every state in which they will provide care and/or render services for Molina Members. Telemedicine Practitioners are required to be licensed in the state where they are located and the state the Member is located.
- **Drug Enforcement Agency (DEA) or CDS Certificate** –Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA certificate in every state where the Practitioner provides care to Molina Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) certificate** – Practitioners must hold a current, valid Michigan CDS certificate. Practitioners working from Indiana practice locations must meet CDS requirements in those states.
- **Specialty** –Practitioners must only be credentialed in the specialty in which they have adequate education and training. Providers 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 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** – 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 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 body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.

- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioners must not be currently sanctioned, excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the Practitioner's activities of 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:

[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.

- Criminal convictions including any convictions, guilty pleas, or adjudicated pretrial diversions for crimes against a person such as murder, rape, assault and other similar crimes.
- Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
- Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
- Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances, or similar crimes.

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

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

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

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

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

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

- Their requirement to submit a written response within 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, corrections will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 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. The 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 rights are published on the Molina website and are 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.

Professional Review Committee (PRC)

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

Notification of Credentialing Decisions

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

Recredentialing

Molina recredentials every Practitioner at least every 36 months.

Excluded Providers

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

Pursuant to section 1128 of the SSA, Molina and its Subcontractors may not subcontract with an Excluded Provider/person. Molina and its Subcontractors shall terminate subcontracts immediately when Molina and its Subcontractors become aware of such excluded Provider/person or when Molina and its Subcontractors receive notice. Molina and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this

transaction by any Federal department or agency. Where Molina and its Subcontractors are unable to certify any of the statements in this certification, Molina and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

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

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **The OIG High Risk list –** Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each State's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Monitor for Medicare exclusions through the CMS MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database (NPDB)** – 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. Claims
4. Complex case management
5. CMS Preclusion List monitoring
6. Other clinical and administrative functions

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

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and reviewed by Molina Delegation Oversight staff for compliance with performance expectations within the timeline indicated by Molina.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Molina's guidelines or regulatory requirements, Molina may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Molina may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Molina determines that is the best course of action.

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

17. Pharmacy

Prescription drug therapy is an integral component of your patient's comprehensive treatment program. Molina's goal is to provide our Members with high quality, cost effective drug therapy. Molina works with our Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are offered. Molina covers prescription and certain over-the-counter drugs found on the prescription drug Formulary.

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 Member 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) 322-4077.

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 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

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

Quantity Limitations

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

Quantity limitations have been placed on certain medications to ensure safe and appropriate use of the medication.

Age Limits

Some medications may have age limits. Age limits align with current U.S. Food and Drug Administration (FDA) 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 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 a prior authorization form. Clinical evidence must be provided and is taken into account when evaluating the request to determine medical necessity. The use of 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, prior authorization must be obtained through the standard prior authorization 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 prior authorization 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 prior authorization request forms. The following information MUST be included for the request form to be considered complete:

- Member first name, last Name, date of birth and Molina Member ID 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 prior authorization 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 prior authorization form in its entirety, including medical justification and/or supporting clinical notes.

Fax a completed Medication Prior Authorization Request form to Molina at (888) 373-3059. A blank Medication Prior Authorization Request form may be obtained by accessing MolinaMarketplace.com or by calling (855) 322-4077.

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) via electronic medical Claim submission.

During the utilization management review process, Molina will review the requested medication for the most cost-effective, yet clinically appropriate benefit (medical or pharmacy) of select specialty medications. All reviewers will first identify Member eligibility, any federal or state regulatory requirements, and the Member specific benefit plan coverage prior to determination of benefit processing.

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

Newly FDA-approved medications are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee. "Buy-and-bill" drugs are pharmaceuticals which a Provider purchases and administers, and for which the Provider submits a claim to Molina for reimbursement.

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

Pain Safety Initiative (PSI) Resources

Safe and appropriate opioid prescribing and utilization is a priority. 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.

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