



Provider Manual

**Molina Healthcare of Michigan, Inc.
(Molina Healthcare or Molina)**

**2019 Molina Marketplace Product*
Effective January 1, 2019**

*Molina's Health Benefit Exchange product is now known as the Molina Marketplace product

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1. Contact Information for Providers

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax-ID changes, Provider denied Claims review, contracting, and training. The department has Provider Services Representatives who serve all of Molina's Provider network. Eligibility verifications can be conducted at your convenience via Molina's Provider Portal.

Provider Services	
Address:	Molina Healthcare of Michigan, Inc. 880 West Long Lake Rd, Suite 600 Troy, Michigan 48098
Phone:	(855) 322-4077
Fax:	(248) 925-1784

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding State holidays.

Member Services	
Address:	Molina Healthcare of Michigan, Inc. 880 West Long Lake Rd, Suite 600 Troy, Michigan 48098
Phone:	(888) 560-4087
TTY/TDD:	711

Claims Department

Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal).

- Access the Provider Portal (<https://provider.MolinaHealthcare.com>)
- EDI Payer ID 38334

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions, contact Provider Services at (855) 322-4077.

Claims Recovery Department

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

Claims Recovery	
Address:	Molina Healthcare of Michigan, Inc. Attn: Corporate Claims Recovery 200 Oceangate Blvd., Suite 100 Long Beach, CA 90802
Phone:	(866) 642-8999

Compliance and Fraud AlertLine

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

Molina Healthcare AlertLine	
Phone:	(866) 606-3889
Website:	https://MolinaHealthcare.alertline.com

Credentialing Department

The Credentialing Department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Molina network.

Credentialing	
Address:	Molina Healthcare of Michigan, Inc. 880 West Long Lake Rd., Suite 600 Troy, Michigan 48098
Phone:	(855) 322-4077
Fax:	(248) 925-1757

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, seven (7) days a week to assess symptoms and help make good health care decisions.

Nurse Advice Line (HEALTHLINE) 24 hours per day, 365 days per year	
English Phone:	(888) 275-8750
Spanish Phone:	(866) 648-3537
TTY/TDD:	711 Relay

Healthcare Services (UM) Department

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

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

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

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

- Submit requests directly to Molina via the Provider Portal. See our Provider Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.

Healthcare Services Authorizations & Inpatient Census	
Provider Portal:	https://provider.MolinaHealthcare.com
Address:	Molina Healthcare of Michigan, Inc. 880 West Long Lake Rd. Troy, Michigan 48098
Phone:	(855) 322-4077
Fax:	(800)594-7404

Health Management

Molina's Health Management includes weight management, smoking cessation, and certain disease related programs. These services can be incorporated into the Member's treatment plan to address the Member's health care needs.

Weight Management and Smoking Cessations Programs	
Phone:	(866)-472-9483
Fax:	(562) 901-1176
Health Management Programs	
Phone:	(866) 891-2320
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:

Behavioral Health	
Address:	Molina Healthcare of Michigan, Inc. 880 West Long Lake Rd. Troy, Michigan 48098
Phone:	(888) 898-7969 24 Hours per day, 365 day per year: (800) 273-8255

Pharmacy Department

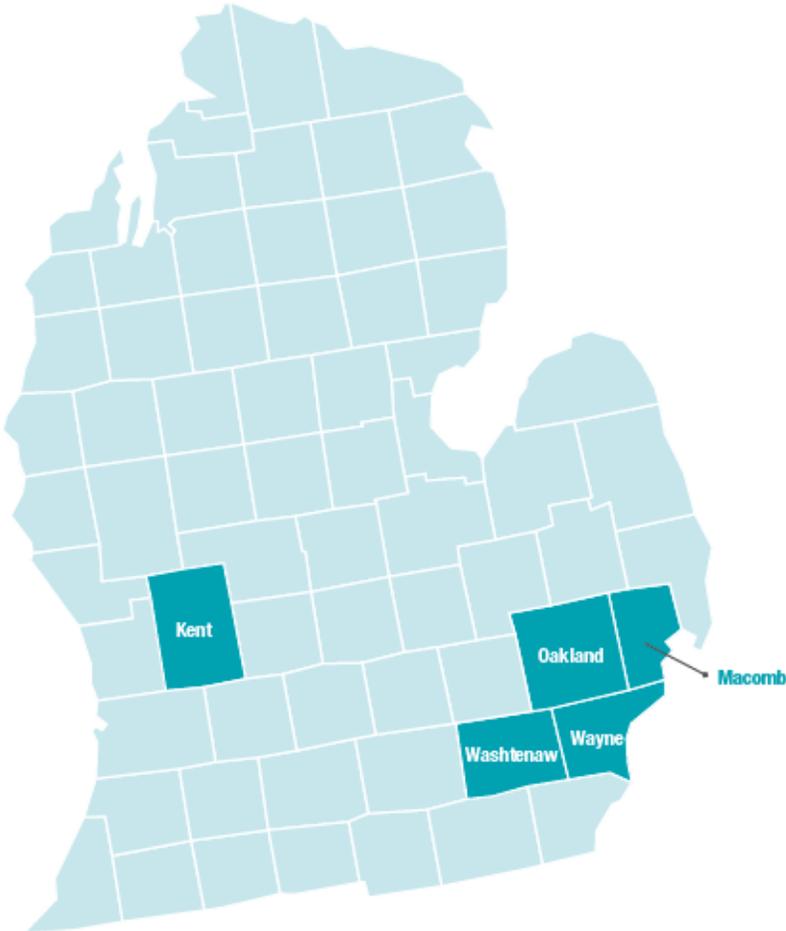
Prescription drugs are covered by Molina, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the <https://www.MolinaHealthcare.com> website, or by contacting Molina at (855) 322-4077.

Quality

Molina maintains a Quality Department to work with Members and Providers in administering Molina's Quality Programs.

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

Molina Service Area



2. Provider Responsibilities

Nondiscrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Marketplace website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

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

Civil Rights Coordinator

200 Oceangate, Suite 100

Long Beach, CA 90802

Toll Free: (866) 606-3889

TTY/TDD: 711

On Line: <https://MolinaHealthcare.AlertLine.com>

Email: civil.rights@MolinaHealthcare.com

Facilities, Equipment and Personnel

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

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 Provider Network and Members.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA® required element. Invalid information can negatively impact Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing (some changes can be made online) at least thirty (30) days in advance, when possible, of changes such as, but not limited to:

- Change in office location(s), office hours, phone, fax, or email
- Addition or closure of office location(s)
- Addition or termination of a Provider (within an existing clinic/practice)
- Change in Tax ID and/or National Provider Identifier (NPI)
- Opening or closing your practice to new patients (PCPs only)
- Any other information that may impact Member access to care

Please visit our Provider Online Directory at <https://providersearch.MolinaHealthcare.com> to validate and correct most of your information. A convenient Provider web form can be found on the Provider On Line Directory (POD) and additionally on the Provider Portal at <https://provider.MolinaHealthcare.com>, or notify your Provider Services Representative or contact the Provider Services Department at (855) 322-4077 if your information needs to be updated or corrected.

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 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. Providers are required to provide timely responses to such communications.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health

plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic claims appeal and registration for and use of Molina's Provider Portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Molina Provider Portal.

Any Provider insisting on paper claims submission and payment via paper check will be ineligible for Contracted Provider status within the Molina network.

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by registering for Molina's Provider Portal, and submitting electronic claims upon entry into the network. Providers entering the network as a Contracted Provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network.

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

If a Provider does not comply with Molina's Electronic Solution Requirements, the Provider's claim will be denied.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

- Electronic Claims Submission Options
- Electronic Payment (Electronic Funds Transfer) with Electronic Remittance Advice (ERA)
- Provider Portal

Electronic Claims Submission Requirement

Molina requires Participating Providers to submit claims electronically. Electronic claims submission provides significant benefits to the Provider including:

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the Provider Portal. See our Provider Portal Quick Reference Guide <https://provider.MolinaHealthcare.com> or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 38334, refer to our website www.MolinaHealthcare.com/ for additional information.



While both options are embraced by Molina, Providers submitting claims via Molina's Provider Portal (available to all Providers at no cost) offers a number of claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims

Electronic claims submitting benefits include:

- Ability to add attachments to claims.
- Submit corrected claims.
- Easily and quickly void claims.
- Check claims status.
- Receive timely notification of a change in status for a particular claim.
- Ability to save incomplete/un-submitted claims.
- Create/manage claim templates.

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

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, the ability to have searchable ERAs, and to 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.

Below is the link to register with Change Healthcare ProviderNet to receive electronic payments and remittance advices. Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website: www.MolinaHealthcare.com.

Any questions during this process should be directed to Change Healthcare Provider Services at wco.provider.registration@changehealthcare.com or 877-389-1160.

Provider Portal

Providers are required to register for and utilize Molina's Provider Portal. The Provider Portal is an easy to use, online tool available to all of our Providers at **no cost**. The Provider Portal offers the following functionality:

- Verify and print Member eligibility – As well as view benefits, covered services and Member health record.
- Member Roster – View a list of assigned membership for PCP(s).
- Claims Functions
 - Professional and Institutional Claims (individual or multiple claims)
 - Receive notification of Claims status change
 - Correct Claims
 - Void Claims
 - Add attachments to previously submitted claims
 - Check Claims status
 - Export Claims reports
 - Create and Manage Claim Templates
 - Open Saved Claims
- Prior Authorizations/Service Requests
 - Create and submit Prior Authorization/Service Requests
 - Check status of Authorization/Service Requests
 - Receive notification of change in status of Authorization/Service Requests
- View HEDIS® Scores and compare to national benchmarks
- Appeals
 - Create and submit a claim appeal
 - Add appeal attachments to appeal
 - Receive email confirmation

Third Party Billers can access and utilize all Claim Functions. Third Party Billers no longer have to phone in to get Claim updates and to make changes. All Claim functionalities are now available for third Party Billers online at Molina's Provider Portal.

Balance Billing

Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers may not charge Members fees for covered services beyond copayments, deductibles or coinsurance.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider. Balance billing a Molina Member for services covered by Molina is prohibited. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.

For additional information please refer to the Compliance and Claims and Compensation sections 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 be approved by Molina prior to use. Please contact your Provider Services Representative for information and review of proposed materials.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Member materials (such as Evidence of Coverage documents). A link to these rights and responsibilities is available in the Member Rights and Responsibilities section in this Provider Manual.

Member Eligibility Verification

Providers should verify eligibility of Molina Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Molina places the responsibility for eligibility verification on the Provider of services.

Possession of a Molina ID Card does not guarantee Member eligibility or coverage. A Provider must verify a recipient's eligibility each time the recipient presents to their office for services. More information on Member eligibility verification options is available in the Eligibility, Enrollment, Disenrollment and Grace Period section of this Manual.

Member Cost Share

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

Healthcare Services (Utilization Management and Case Management)

Providers are required to participate in and comply with Molina's Healthcare Services programs and initiatives. Clinical documentation necessary to complete medical review and decision making is to be submitted to Molina through electronic channels such as the Provider Portal. Clinical documentation can be attached as a file and submitted securely through the Provider Portal. Please see the Healthcare Services section of the Manual for additional details about these and other Healthcare Services programs.

In Office Laboratory Tests

For more information about In-Network Laboratory Providers, please consult the Molina Provider Directory (<https://providersearch.MolinaHealthcare.com/>). For testing available through In-Network Laboratory Providers, or for a list of In-Network Laboratory Provider patient services centers, please reach out to the In-Network Laboratory Provider.

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

Referrals

A referral is 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 (please refer to the Healthcare Services section of this Manual). 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 in the patient's medical record any referrals that are. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Healthcare Marketplace. In the case of Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and Emergency Services.

There may be circumstances in which referrals may require an out of network Provider; prior authorization will be required from Molina except in the case of Emergency Services.

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

Admissions

Providers are required to comply with Molina's facility admission, prior authorization, and Medical Necessity review determination procedures.

Participation in Utilization Review and Care Management Programs

Providers are required to participate in and comply with Molina's utilization review and Care Management programs, including all policies and procedures regarding prior authorizations. This includes the use of an electronic solution for the submission of documentation required for medical review and decision making. Providers will also cooperate with Molina in audits to identify, confirm, and/or assess utilization levels of covered services.

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. Each year, we review feedback received from PCPs and specialists and facilities to determine if the level of satisfaction with the information provided across settings or between Providers is sufficient.

Treatment Alternatives and Communication with Members

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

Prescriptions

Providers are required to adhere to Molina's drug formularies and prescription policies.

Pain Safety Initiative (PSI) Resources

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

Molina is dedicated to ensuring Providers are equipped with additional resources, which can be found on the Molina Provider website. Providers may access additional Opioid-safety and Substance Use Disorder resources at www.MolinaHealthcare.com under the Health Resource tab. Please consult with your Provider Services representative or reference the medication formulary for more information on Molina's Pain Safety Initiatives.

Participation in Quality Programs

Providers are expected to participate in Molina's Quality Programs and collaborate with Molina in conducting peer review and audits of care rendered by Providers.

Additional information regarding Quality Programs is available in the Quality section of this Provider Manual.

Access to Care Standards

Molina is committed to providing timely access to care for all Members in a safe and healthy environment. Molina will ensure Providers offer hours of operation no less than offered to commercial Members. Access standards have been developed to ensure that all health care services are provided in a timely manner. The PCP or designee must be available twenty-four (24) hours a day, seven (7) days a week to Members for Emergency Services. This access may be by telephone. For additional information about appointment access standards please refer to the Quality section of this Manual.

Site and Medical Record-Keeping Practice Reviews

As a part of Molina's Quality Improvement Program, Providers are required to maintain compliance with certain standards for safety, confidentiality, and record keeping practices in their practices.

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures.

Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

CMS has specific guidelines for the retention and disposal of Medicare records. Please refer to [CMS General Information, Eligibility, and Entitlement Manual](#), Chapter 7, Chapter 30.30 for guidance.

Delivery of Patient Care Information

Providers must comply with all State and Federal Laws, and other applicable regulatory and contractual requirements to promptly deliver any Member information requested by Molina for use in conjunction with utilization review and management, grievances, peer review, HEDIS® Studies, Molina's Quality Programs, or claims payment. Providers will further provide direct access to patient care information (hard copy or electronic) as requested by Molina and/or as required to any governmental agency or any appropriate State and Federal authority having jurisdiction.

Compliance

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

Confidentiality of Member Protected Health Information (PHI) and HIPAA Transactions

Molina requires that Providers respect the privacy of Molina Members (including Molina Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and Member PHI.

Additionally, Providers must comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Providers must obtain a National Provider identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina. Please refer to the Compliance section of this Provider Manual for additional information.

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 appeals, the Provider will participate by providing medical records and/or statement as needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years, and retained further if the records are under review or audit until such time that the review or audit is complete.

Please refer to the Complaints, Grievance and Appeals Process section of this Manual for additional information regarding this program.

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 requests for information related to the credentialing or re-credentialing process.

Providers must notify Molina no less than thirty (30) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the Provider's recredentialing date.

More information about Molina's Credentialing program, including Policies and Procedures is available in the Credentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Molina's delegation requirements and delegation oversight.

3. Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency 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, gender, gender identity, sexual orientation, age 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 www.MolinaHealthcare.com, from your local Provider Services Representative and by calling Molina Provider Services at (855) 322-4077.

Nondiscrimination of Health Care Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the ACA, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina Marketplace website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care.

Providers can refer Molina Members who are complaining of discrimination to the Molina Civil Rights Coordinator at: (866) 606-3889, or TTY, 711.

Members can also email the complaint to civil.rights@MolinaHealthcare.com.

Should you or a Molina Member need more information you can refer to the Health and Human Services website for more information: <https://www.federalregister.gov/d/2016-11458>

Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staffs, 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 intends to enhance 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 Services or online/webinar training modules.

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

1. Written materials;
2. On-site cultural competency training;
3. Online cultural competency provider training; and,
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications

Integrated Quality Improvement – Ensuring Access

Molina ensures Member access to language services such as oral interpreting, American Sign Language (ASL), written translation and access to programs, aids, and services that are congruent with cultural norms, support Members with disabilities, and assist Members with Limited English Proficiency.

Molina develops Member materials according to Plain Language Guidelines. Members or Providers may also request written Member materials in alternate languages and formats, leading to better communication, understanding and Member satisfaction.

Online materials found on www.MolinaHealthcare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

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

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 plan's membership
 - Revalidate data at least annually
 - Contracted Providers to assess gaps in network demographics
- Local geographic population demographics and trends derived from publicly available sources (Community Health Needs Assessment)
- Applicable national demographics and trends derived from publicly available sources
- Network Assessment
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS® results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.
- Comparison with selected measures such as those in Healthy People 2020.

Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES) Linguistic Services

Molina provides oral interpreting of written information to any plan Member who speaks any non-English language regardless of whether that language meets the threshold of a prevalent non-English language. Molina notifies plan Members of the availability of oral interpreting services upon enrollment, and informs them how to access oral interpreting services at no cost to them on all significant Member materials. Molina serves a diverse population of Members with specific cultural needs and preferences. Providers are responsible for supporting access to interpreter services at no cost for Members with sensory impairment and/or who have Limited English Proficiency.

24 Hour Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Molina's Contact Center toll free at (888 560-4087).

If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

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.

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 being notified of his or her right to have a qualified interpreter at no cost.

Members who are Deaf or Hard of Hearing

Molina provides a TTY/TDD connection, which may be reached by dialing 711. This connection provides access to Member Services, Provider Services, Quality, Healthcare Services and all other health plan functions.

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

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

Nurse Advice Line

Molina provides twenty four (24) hours/seven (7) days a week Nurse Advice Services for Members. The Nurse Advice Line provides access to twenty-four (24) hour interpretive services. Members may call Molina Healthcare's Nurse Advice Line directly (English line (888) 275-8750) or (Spanish line at (866) 648-3537) or for assistance in other languages. The Nurse Advice TTY/TDD is 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Evidence of Coverage (EOC) and on the Molina website. The EOC that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link: <http://www.MolinaHealthcare.com/members/mi/en-US/mem/marketplace/quality/Pages/rights.aspx>

EOCs are available on the [Provider Portal](#) and Molina's Member Website: <http://www.MolinaHealthcare.com/members/mi/en-US/hp/marketplace/plans/Pages/allplans.aspx>

Member Rights and Responsibilities are outlined under the heading "your Rights and Responsibilities" within the EOC document.

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

For additional information, please contact Molina Healthcare at (855) 322-4077, Monday through Friday, 8:00 a.m. to 5:00 p.m. TTY users, please call 711.

5. Eligibility, Enrollment, Disenrollment & Grace Period

Enrollment in Michigan's Marketplace Program

The Michigan Marketplace Program is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act. It is administered by the Molina Marketplace.

To enroll with Molina, the Member, his/her representative, or his/her responsible parent or guardian must follow enrollment process established by Molina Marketplace. Michigan Marketplace Program will enroll all eligible Members with the health plan of their choice.

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

Effective Date of Enrollment

Coverage shall begin as designated by the Marketplace Exchange on the first day of a calendar month. If the enrollment application process is completed by the 15th of the month, the coverage will be effective on the first day of the next month. If enrollment is completed after the 15th of the month, coverage will be effective on the first day of the second month following enrollment.

Newborn Enrollment

When a Molina Marketplace Subscriber or their Spouse gives birth, the newborn is automatically covered under the Subscriber's policy with Molina for the first 31 days of life. In order for the newborn to continue with Molina coverage past this time, the infant must be enrolled through the Marketplace Exchange with Molina on or before 60 days from the date of birth.

PCP's are required to notify Molina via the Pregnancy Notification Report immediately after the first prenatal visit and/or positive pregnancy test for any Molina Member presenting themselves for health care services.

Inpatient at time of Enrollment

With Member assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior Insurer's liability for payment of Inpatient Hospital Services through discharge of any Inpatient admission.

If there is no transition of care provision through Member's prior Insurer or Member did not have coverage through an Insurer at the time of admission, Molina would assume

responsibility for Covered Services upon the effective date of Member's coverage with Molina, not prior.

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:

- Molina Provider Portal <https://provider.MolinaHealthcare.com>.
- Molina Provider Services automated IVR system at (855) 322-4077

Possession of a Marketplace 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

Card Front

Molina Marketplace			
ID #: 2074102408			
Member: TEST TESTER502408		Plan: Molina Silver 250 Plan	
DOB: 01/08/1985			
Subscriber Name: TEST TESTER402408			
Subscriber ID: 2073102408		Plan Year: 2018	
<hr/>			
Provider: BRANDI N BASKET			
Provider Phone: (586) 619-9986			
Provider Group: MYCARE HEALTH CENTER			
<hr/>			
Medical Cost Share	Prescription Drugs		
Primary Care: \$30	Generic Drugs: \$20		
Specialist Visits: \$75	Preferred Brand Drugs: \$60		
Urgent Care: \$75	Non-Preferred Brand Drugs: 50% after deductible		
ER Visit: \$400 after deductible	Specialty Drugs: 50% after deductible		
<small>Cost Shares are a summary only. Visit MyMolina.com for plan details.</small>			
<small>Molina Healthcare of Michigan, Inc. Rx Bin: 004336 Rx PCN: ADV Rx Group: RX0847</small>			

Card Back

<p>This card is for identification purposes only and does not prove eligibility for service.</p> <p>Member: Emergencies (24 hrs): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.</p> <p>Miembro: Emergencias (24 horas al día): si una emergencia médica puede resultar en muerte o discapacidad, llame al 911 inmediatamente o acuda a la sala de emergencias más cercana. No necesita autorización previa para los servicios de emergencia.</p> <p>Remit claims to: Molina Healthcare, P.O. Box 22668, Long Beach, CA 90801</p> <p>Member Services: (888) 560-4087 (TTY/TTD: 711)</p> <p>24 Hour Nurse Advice Line: (888) 275-8750</p> <p>Línea de Consejos de Enfermeras 24 horas al día (español): (866) 648-3537</p> <p>CVS Caremark Pharmacy Help Desk: (800) 364-6331</p> <p>Provider: Notify the health plan within 24 hours of any inpatient admission at the hospital admission notification phone number.</p> <p>Prior Authorization/Notification of Hospital Admission and Covered Services: (855) 322-4077</p>	<p>MolinaMarketplace.com</p>
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Members are reminded in their Agreement/COC/EOC/Policy to carry ID cards with them when requesting medical or pharmacy services. It is the Provider's responsibility to ensure Molina Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an Emergency Medical Condition exists, Providers may

refuse service if the Member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to terminate coverage for any reason at any time. However, beyond the open-enrollment period, if a Member elects to terminate coverage with Molina Marketplace, they are not eligible to re-enroll with another health plan until the following year's open-enrollment period unless there is a life event, and they qualify for a Special Enrollment Period (SEP) or if they are American Indian or Alaska Native. Members may discontinue Molina coverage by contacting the Marketplace Exchange.

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

Involuntary Disenrollment

Under very limited conditions and in accordance with the Marketplace Exchange guidelines, Members may be involuntarily disenrolled from a Molina Marketplace program. With proper written documentation and approval by Michigan Department of Health and Human Services or its Agent; the following are acceptable reasons for which Molina may submit Involuntary Disenrollment requests to MI Enrolls:

- Delinquency of payment, past defined grace period(s)
- Member has moved out of the Service Area
- Member death
- Member's continued enrollment seriously impairs the ability to furnish services to this Member or other Members
- Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness (this may not apply to Members refusing medical care)
- Member's utilization of services is fraudulent or abusive
- Member ages out of coverage (e.g., dependent child age >26PCP Assignment)

Molina will offer each Member a choice of Primary Care Providers (PCPs). After making a choice, each Member will have a single PCP. Molina will assign a PCP to those Members who did not choose a PCP at the time of Molina selection.

Molina will take into consideration the Member's last PCP (if the PCP is known and available in Molina's contracted network), closest PCP to the Member's home address, ZIP code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN).. Molina will allow pregnant Members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

PCP Changes

Members can change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes requested on or after the 26th of the month will be in effect on the first day of the second calendar month.

Grace Period

Definitions

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 months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with State Law to 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 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 one month 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 termed effective 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.

Service Alerts

When a Member is in the grace period, Molina Healthcare, Inc. ("Molina") will include a service alert on the Web Portal, interactive voice response (IVR) and in the call centers. This alert will provide detailed information about the Member's grace period status, including which month of the grace period that the Member is in the grace period (first month vs. second and third) as well as information about how authorizations and Claims will be processed during this time. Providers should verify both the eligibility status AND any service alerts when checking a Member's eligibility. For additional information about how authorizations and Claims will be processed during this time, please refer to the Member Evidence of Coverage, or contact Molina's Provider Services Department at (888) 898-7969.

Notification

All Members will be notified upon entering the grace period. Additionally, when an APTC Member enters the grace period, Molina will provide notification to Providers who submit Claims for services rendered to the APTC Member during the grace period. This notification will advise Providers that payment for services rendered during the second and third months of the grace period may be denied or subject to recovery (where Claim payment is made prior to the expiration of the grace period) if the APTC Member's premium is not *paid in full* prior to the expiration of the third month of the grace period.

All Members will be notified upon entering the grace period. Additionally, when an APTC Member enters the grace period, Molina will provide notification to Providers who submit Claims for services rendered to the APTC Member during the grace period. This notification will advise Providers that payment for 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.

All Members will be notified upon entering the grace period. Additionally, when an APTC Member enters the grace period, Molina will notify Providers as follows:

- The APTC Member's assigned PCP will receive notification that the APTC Member entered the grace period
- Providers who have submitted Claims for the APTC Member in the two months prior to the start of the grace period will receive notification that the APTC Member entered the grace period

- Providers who submit Claims for services rendered during the grace period will receive notification that the APTC Member is in the grace period

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

Prior Authorizations

All authorization requests will be reviewed based on Medical Necessity and will expire after thirty (30) 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.

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 while the APTC Member is in the grace period for services rendered during the second and third months of an APTC Member's grace period will be processed according to Molina's standard processes, within established turn-around-times, and in accordance with State and Federal statutes and regulations. 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 retroactively deny Claims for services rendered in the second and third months of the grace period, and will issue a re-coup notice to the Provider(s) if appropriate. Pharmacy Claims will be processed based on program drug utilization review and formulary edits; the APTC Member will be charged one-hundred percent (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.

6. Benefits and Covered Services

Molina covers the services described in the Summary of Benefits and Evidence of Coverage (EOC) documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina at (888) 569-4087, Monday through Friday, 8:00 a.m. to 5:00 p.m. except holidays.

Member Cost Sharing

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

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

Services Covered by Molina: Links to Summaries of Benefits and Evidence of Coverage (EOC)

The following web link provides access to the Summary of Benefits guides and EOCs for the 2019 Molina Marketplace products offered in Michigan. Detailed information about benefits and services can be found in the 2019 Evidence of Coverage (EOC) booklets that made available to Molina Marketplace Members.

<https://www.MolinaHealthcare.com/members/mi/en-US/hp/marketplace/plans/Pages/allplans.aspx>

Obtaining Access to Certain Covered Services

Prescription drugs

Prescription drugs are covered by Molina, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the www.MolinaHealthcare.com/ website, or by contacting Molina. Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina at (888) 560-4087 or at www.MolinaMarketplace.com.

Non-Formulary Drug Exception Request Process

There are two types of requests for clinically appropriate drugs that are not covered under the Member's Marketplace plan type:

- "Expedited Exception Request" for urgent circumstances that may seriously jeopardize life, health or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- "Standard Exception Request"
- The Member and/or Member's Representative and the prescribing Provider will be notified of Molina's decision no later than:
 - Twenty-four (24) hours following receipt of request for Expedited Exception Request
 - Seventy-two (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:
 - Twenty-four (24) hours following receipt of the request for external review of the Expedited Exception Request
 - Seventy-two (72) hours following receipt of the request for external review of the Standard Exception Request

Mail Order Availability of Drug Formulary Prescription Drugs

Molina offers Members a mail order option for prescription drugs on Our Drug Formulary. This option applies only to drugs listed in the formulary with the designation "MAIL." These prescription drugs can be mailed to Members within ten (10) days from order request and approval. Cost Sharing for a ninety (90)-day supply by mail order is two times the Cost Sharing listed on the Schedule of Benefits for a standard thirty (30)-day supply.

Members may request mail order service in the following ways:

- Members can order online. Visit www.MolinaHealthcare.com/marketplace
- and select the mail order option. Then follow the prompts.
- Members can call the FastStart® toll-free number at (800) 875-0867. Members will be required to provide: Molina Marketplace Member number (found on the card), prescription (medication) name(s), prescribing Provider's name and phone number, and Member's mailing address
- Members can mail a mail-order request form. Visit www.MolinaHealthcare.com/marketplace and select the mail order form option. Members must complete and mail the form to the address on the form along with payment.
- Providers can call, fax or electronically prescribe using the toll-free FastStart® physician number (800) 378-5697.

To speed up the process, Providers will need the Molina Marketplace Member number (found on the ID card), Member date of birth, and Member mailing address.

Injectable and Infusion Services

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

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

Access to Mental Health and Substance Abuse Services

Members in need of Mental Health or Substance Abuse Services can be referred by their PCP for services or Members can self-refer by calling Molina's Behavioral Health Department at **(866) 898-7969**. Molina's Nurse Advice Line is available twenty-four (24) hours a day, seven (7) days a week for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the EOCs linked above, or by contacting Molina. All outpatient professional mental health and substance abuse services will be charged the primary care copay equivalent.

Emergency Mental Health or Substance Abuse Services

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

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

Out of Area Emergencies

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

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

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

Obtaining Mental Health or Substance Abuse Services

Please call the appropriate Member Services or Provider Services number or the Behavioral Health Department to find a mental health or substance abuse Provider.

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.

Non-Emergency Medical Transportation

Molina covers non-routine, non-emergency Medically Necessary transportation, such as van or ambulance transportation, to Participating Provider facilities. Prior Authorization may be required. Covered non-emergency medical transportation services will be provided at the cost share identified within the Schedule of Benefits for inpatient hospital services, up to the less of any negotiated rate or Molina's allowed amount for such services.

Please note: Molina Marketplace Members are not covered for non-emergency medical transportation services provided in an out-of-area or at a non-participating Provider facility, Members will be one-hundred percent (100%) responsible for payment of services provided by a Non-Participating Provider.

Additional information regarding the availability of this benefit is available by contacting Customer Service at (888) 560-4087.

Preventive Care

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

<http://www.MolinaHealthcare.com/providers/common/marketplace/resource/Pages/hlthguide.aspx>

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (888) 275-8750.

Emergency Services

Emergency Services means: Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if any Emergency Medical Condition exists. If an Emergency Medical Condition exists, Emergency Services includes the

care, treatment, or surgery for a Covered Service by a physician necessary to relieve or eliminate the Emergency Medical Condition within the service capability of a hospital. Emergent and urgent care Services are covered by Molina without an authorization. This includes non-contracted Providers inside or outside of Molina's service area.

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

Nurse Advice Line

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

Nurse Advice Line (24 Hours)	
English Phone:	(888) 275-8750
Spanish Phone:	(866) 648-3537
TTY/TDD:	711 Relay, Or (866) 735-2929 (English) (866) 833-4703 (Spanish)

Molina is committed to helping our Members:

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

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

Health Management Programs

Molina's Health Management programs provide patient education information to Members and helps facilitate Provider access to these chronic disease programs and services. Health Management staff; Registered Nurse, Registered Dietitian, Licensed Vocational Nurse, Social Worker, and or Health Educator are available telephonically to share information about Molina Programs. They will assist Members with preventative education and management of their conditions. He/she will collaborate with the Member and Provider relating to specific needs identified for best practices. Molina requests that you as a Provider also help us identify Members who may benefit from these programs. Members can request to be enrolled or dis-enrolled in these programs. These include programs, such as:

- Asthma

- Depression
- Weight Management
- Smoking Cessation

For more info about our programs, please call:

- Provider Services Department at (855) 322-4077
- (English) TTY/TDD at 711
- (Spanish) TTY/TDD at 711
- Visit www.MolinaHealthcare.com

Program Eligibility Criteria and Referral Source

Health Management Programs are designed for Molina Members with a confirmed diagnosis. Members participate in programs for the duration of their eligibility with the plan's coverage or until the Member opts out. Each identified Member will receive specific educational materials and other resources in accordance with their assigned stratification level. Additionally, all identified Members will receive regular educational newsletters. The program model provides an "opt-out" option for Members who contact Molina Member Services and request to be removed from the program.

Multiple sources are used to identify the total eligible population. These may include the following:

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim 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;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and,
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

Contracted Providers are automatically notified whenever their patients are enrolled in a health management program. 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; and,
- Preventive Health Guidelines

Additional information on health management programs is available from your local Molina HCS Department **toll free at (888) 898-7969**.

Weight Management

Molina's Weight Management program is comprised of one-on-one telephonic education and coaching by a case manager to support the weight management needs of the Member. The Health Education staff work closely with the Member, providing education on nutrition, assessing the Member's readiness to lose weight, and supporting the Member throughout their participation in the Weight Management Program.

The Health Education staff work closely with the Member's Provider to implement appropriate intervention(s) for Members participating in the program. The program consists of multi-departmental coordination of services for participating Members and uses various approved health education/information resources such as: Centers For Disease Control, National Institute of Health and Clinical Care Advance system for health information (i.e. Healthwise Knowledgebase). Health Education resources are intended to provide both general telephonic health education and targeted information based on the needs of the individual.

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4077.

Smoking Cessation

Molina's Smoking Cessation Program uses a combination of telephonic outreach by a Care Managers to support the smoking cessation needs of the Member.

The team works closely with the Member to develop a smoking cessation plan of care. Members are encouraged to work with their contracted Providers to determine appropriate pharmacological aid, as needed.

Molina's Smoking Cessation Program is designed for adults who are active Molina Healthcare Members eighteen (18) years of age or older upon enrollment in the program. The proposed program model is an "invitational" design with the Member agreeing to participate in the program.

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4077.

Breathe with EaseSM Program

Molina Healthcare provides an asthma health management program called Breathe with EaseSM, designed to assist Members in understanding their disease. Molina has a special interest in asthma, as it is the number one chronic diagnosis for our Members. This program was developed with the help of several community Providers with large asthma populations. The program educates the Member and family about asthma symptom identification and control. Our goal is to partner with you to strengthen asthma care in the community.

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4077.

Building Brighter Days Adult Depression Management Program

The purpose of the Building Brighter Days - Depression Management Program is a collaborative team approach comprised of health education, clinical case management and provider education. The overall goal is to provide better overall quality of life, quality of care and better clinical outcomes for members who have a primary psychiatric diagnosis of major depressive disorder. This will be accomplished by providing disease-specific measurable goals for Members and their support systems that are also easily measured by Molina staff as well as the member and their support systems. The Molina team works closely with contracted practitioners in the identification assessment and implementation of appropriate interventions for adults with depression.

Molina's Building Brighter Days Program strives to improve outcomes through early identification, continual, rather than episodic, care and monitoring and most importantly interventions focused on self-advocacy and empowerment of the Member.

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4077.

7. Healthcare Services (HCS)

Introduction

Molina provides care management services to Marketplace Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated care management 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. Elements of the Molina medical management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. You can contact the Molina Utilization Management (UM) Department for toll free at (855) 322-4077. The UM Department fax number is (800) 594-7404.

Utilization Management

Molina's UM program ensures appropriate and effective utilization of services. The UM team works closely with the Care Management (CM) team to ensure Members receive the support they need when moving from one care setting to another or when complexity of care and services is identified. To reflect the vital role this process plays in Molina's innovative HCS program, the UM program ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the levels 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, integrating a range of services appropriate to meet individual needs. It maintains flexibility to adapt to changes as necessary and is designed to influence Member's care by:

- Identify medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the 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 while monitoring utilization practice patterns of Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Implementing comprehensive processes to monitor and control the utilization of health care resources;
- Ensuring that services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness;
- Reviewing processes to ensure care is safe and accessible;

- Ensuring that qualified health care professionals perform all components of the UM/CM processes while ensuring timely responses to Member appeals and grievances;
- Ensuring that UM decision tools are appropriately applied in determining Medical Necessity decision.
- Identify and assess the need for Case Management/Health Management through early identification of high or low service utilization and high cost, chronic or long term diseases;
- Promote health care in accordance with local, state and national standards;
- Identify events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance by ensuring care is safe and accessible
- Continually seek to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decision.
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

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

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

This Molina Provider Manual contains excerpts from Molina's Healthcare Services Program Description. For a complete copy of your state's Healthcare Services Program Description you can access the Molina website or contact the UM Department to receive a written copy. You can always find more information about Molina's UM including information about obtaining a copy of clinical criteria used for authorizations and how to contact a UM reviewer on Molina's website or calling the UM Department.

Molina's UM Department is designed to provide comprehensive health care management. This focus, from prevention through treatment, benefits the entire care delivery system by effectively and efficiently managing existing resources to ensure quality care. It also ensures that care is both medically necessary and demonstrates an appropriate use of resources based on the severity of illness and the site of service. Molina works in partnership with Members and Providers to promote a seamless delivery of health care services. Molina's managed care programs balance a combination of benefit design, reimbursement structure, information analysis and feedback, consumer education, and active intervention that manages cost and improves quality. Molina maintains a medical management program to ensure patient safety as well as detect and prevent fraud, waste and abuse in its programs. The Molina medical management program also ensures that Molina only reimburses for services identified as a covered benefit and medically necessary. Elements of the Molina medical management program include medical necessity review, prior authorization, inpatient management and restrictions on the use of non-network Providers.

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.

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to, CMS guidelines, State guidelines, other third party guidelines from recognized professional societies, and advice from authoritative review articles and textbooks. Medical Necessity review may take place prospectively, as part of the inpatient admission notification/ review, or retrospectively.

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all Medical Necessity determination processes. 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 or the Molina Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and the current documents are posted on the Molina website at www.MolinaHealthcare.com.

Requests for prior authorizations to the UM Department may be sent by telephone, fax, mail based on the urgency of the requested service, or via the Provider Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section.

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

- Member demographic information (name, date of birth, Molina ID number, etc.)
- Clinical information sufficient to document the Medical Necessity of the requested service
- Provider demographic information (referring Provider and referred to Provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes
- Location where service will be performed
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions)
- Pertinent medical history (include treatment, diagnostic tests, examination data)
- Requested Length of stay (for inpatient requests)
- Indicate if request is for expedited or standard 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. Prior Authorization is not a guarantee of payment. Payment is contingent upon Member eligibility at the time of service.

Molina makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the Member's clinical situation.

For expedited request for authorization, we make a determination as promptly as the Member's health requires and no later than seventy-two (72) hours after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. For a standard authorization request, Molina makes the determination and provide within fourteen (14) calendar days.

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (855) 322-4077.

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

Requesting Prior Authorization

Provider Portal: Participating Providers are required to use the Molina Provider Portal for prior authorization submissions whenever possible. Instructions for how to submit a Prior Authorization Request are available on the Provider Portal. The benefits of submitting your prior authorization request through the Provider Portal are:

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

Fax: The Prior Authorization form can be faxed to Molina at: (800) 594-7404. If the request is not on the form provided by Molina, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax if the request is urgent or non-urgent. The Definition of expedited/urgent is when the situation where the standard time frame or decision making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function. Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible

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

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:
Molina Healthcare of Michigan, Inc.
Attn: Healthcare Services Dept.
880 W. Long Lake Road
Troy, MI 48098

Affirmative Statement about Incentives

Molina requires that all medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns and ensures, through communications to Providers, Members, and staff, that Molina and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Furthermore, Molina affirms that all UM decision making is based only on appropriateness of care and service and existence of coverage for its Members, and not on the cost of the service to either Molina or the delegated group. Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care. It is important to remember that:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Molina does not specifically reward Providers or other individuals for issuing denials of coverage or care.
- UM decision makers do not receive incentives to encourage decisions that result in underutilization.

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

Medical Groups/IPAs delegated with UM functions must be prior approved by Molina and be in compliance with all current Molina policies. Molina may delegate UM functions

to qualifying Medical Groups/IPAs and delegated entities depending on their 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

Molina HCS staff is accessible by calling (855) 322-4077 during normal business hours, Monday through Friday (except for Holidays) from 8:00 a.m. to 5:00 p.m. for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

Molina's Nurse Advice Line is available to Members and Providers twenty-four (24) hours a day, seven (7) days a week at (888) 275-8750. Primary Care Physicians (PCPs) are notified via fax of all Nurse Advice Line encounters. Molina's Nurse Advice Line handles urgent and emergent after-hours UM calls. Providers can also utilize fax and the Provider Portal for after-hours UM access, as described later in this section.

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff.

Callers may also contact staff directly through a private line. All staff Members identify themselves by providing their first name, job title, and organization.

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

Levels of Administrative and Clinical Review

Molina reviews and approves or denies plan coverage for various services – inpatient, outpatient, medical supplies, equipment, and selected medications. The review types are:

- Administrative (e.g., eligibility, appropriate vendor or Participating Provider, covered services); and,
- Clinical (e.g., Medically Necessary)

The overall review process begins with administrative review followed by initial clinical review if appropriate. Specialist review may be needed as well.

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

All staff involved in the review process have an updated list of services and procedures that require Pre-Service Authorization.

The timelines and procedures are published in the Provider Manual and are available on the www.MolinaHealthcare.com website.

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

Hospitals

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.

Members accessing the emergency department inappropriately will be contacted by Molina Case Managers whenever possible to determine the reason for using Emergency Services.

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

Admissions

Hospitals are required to notify Molina within twenty-four (24) hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. Prior authorization is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Inpatient Management

Elective Inpatient Admissions

Molina requires prior authorization for all elective inpatient admissions to any facility. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays. For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information (see definition above) sufficient to document the Medical Necessity of the admission. Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Inpatient at time of Termination of Coverage

If a Member's coverage with Molina terminates during a hospital stay, all services received after their termination of eligibility are not covered services.

Prospective/Pre-Service Review

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

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

Inpatient Review

Molina performs concurrent inpatient review in order to ensure patient safety, 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 original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina will authorize hospital care as an inpatient, for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or where 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.

Inpatient Status Determinations

Molina's UM staff determine if the collected medical records and 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. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. 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. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

Inpatient Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient. The inpatient review nurses review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Post Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do

not require authorization. Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Molina Member or there was a Molina error, a medical necessity review will be performed. Decisions, in this circumstance, will be based on medical need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence based criteria sets.

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

Readmissions

Hospital readmissions less than thirty-one (31) calendar days from the date of discharge have been found by CMS to potentially constitute a quality of care problem. Readmission review is an important part of Molina's Quality Improvement Program to ensure that Molina Members are receiving hospital care that is compliant with nationally recognized guidelines, as well as Federal and State regulations.

Molina will conduct readmission reviews for applicable participating hospitals of admissions that occur at the same facility or a different facility. If it is determined that the subsequent admission at the same facility is related to the first admission (Readmission), the first payment may be considered as payment in full for both the first and second hospital admissions.

Exceptions

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission
2. The readmission is part of a Medically Necessary, prior authorized or staged treatment plan
3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Non-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 for

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

Except for Emergency Services and out-of-area Urgent Care Services, Marketplace Members must receive Covered Services from Participating Providers; otherwise, the services are not covered. Marketplace Members will be one-hundred percent (100%) responsible for payment and the payments will not apply to towards Deductibles or Annual Out-of-Pocket Maximums.

“Emergency Services” means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if any Emergency Medical Condition exists. If an Emergency Medical Condition exists, Emergency Services includes the care, treatment, or surgery for a Covered Service by a physician necessary to relieve or eliminate the Emergency Medical Condition within the service capability of a hospital.

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

Molina staff work with Providers to assist with coordinating services and benefits for Members with complex needs. It is the responsibility of contracted Providers to assess Members and with the participation of the Member and their representatives, create a treatment care plan. The treatment plan is to be documented in the medical record and is updated as conditions and needs change. In addition, the coordination of care process assists Molina Members, as necessary, in transitioning to other care when benefits end. The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources 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 and Members to ensure efforts are efficient and non-duplicative.

There are two (2) main coordination of care processes for Molina Members. The first occurs when a new Member enrolls in Molina and needs to transition medical care to Molina contracted Providers. There are mechanisms within the enrollment process to identify those Members and reach out to them from the Member & Provider Contact Center (M&PCC) to assist in obtaining authorizations, transferring to contracted DME vendors, receiving approval for prescription medications, etc. The second coordination of care process occurs when a Molina Member's benefits will be ending and they need assistance in transitioning to other care.

The process includes mechanisms for identifying Molina Members whose benefits are ending and are in need of continued care.

Continuity of Care and Transition of Members

It is Molina's policy to provide Members with advance notice when a Provider they are seeing will no longer be in network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member up to ninety (90) days or longer if necessary for a safe transfer to another Provider as determined by Molina or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary for a safe transfer.

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

UM Decisions

A decision is any determination (e.g., an approval or denial) 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 deny requests (adverse determination).

- Discontinuation of a service.
- Payment for temporarily out-of-the-area renal dialysis services.
- Payment for Emergency Services, post stabilization care or urgently needed services.

All Medical Necessity requests for authorization determinations must be based on nationally recognized criteria that are supported by sound scientific, medical evidence. Clinical information used in making determinations include, but are not limited to, review of medical records, consultation with the treating Providers, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

Clinical criteria does not replace State regulations when making decisions regarding appropriate medical treatment for Molina Members. Molina covers all services and items required by State.

Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of medical necessity.

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

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

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself 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 in Michigan must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

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

- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers.

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

Child Abuse:

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 Utilization Management Committee and the proper State agency.

Emergency Services

Emergency Services means: health care services needed to evaluate, stabilize or treat an Emergency Medical Condition. Emergency services are covered on a (24) hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Emergency services are covered on a twenty-four (24) hour basis without the need for prior authorization for all Members experiencing an Emergency Medical Condition.

Molina accomplishes this service by providing a twenty-four (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, the 911 information is given to all Members at the onset of any call to the plan.

For Members within our service area: Molina contracts with vendors that provide twenty-four (24) hour Emergency Services for ambulance and hospitals. An out of network

Emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a Participating Provider facility. Services provided after stabilization in a Non-Participating Provider facility are not covered, and Member will be responsible for payment. Member payments to the Non-Participating Provider facility will not apply to the Member's Deductible or Annual Out-of-Pocket Maximum.

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.

Care Management

Molina Care Management includes Health Management (HM) and Case Management (CM) programs.

Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services.

PCP Responsibilities in Care Management Referrals

The Member's PCP is the primary leader of the health team involved in the coordination and direction of services for the Member.

The case manager provides the PCP with reports, updates, and information regarding the Member's progress through the Care Management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager Responsibilities

The case manager collaborates with all resources involved and the Member to develop a plan of care which includes a multidisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, and a statement of expected outcomes. Jointly, the case manager, Providers, and the Member are responsible for implementing the plan of care. Additionally the case manager:

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team Members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Coordinates appropriate education and encourages the Member's role in self-help

- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

Health Management

Molina's Health Management programs can be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking cessation, weight management, pregnancies, and disease-specific health management programs for Asthma and Depression. Refer to "Benefits and Covered Services" section for detailed information regarding these services.

Health Management's primary focus is on Asthma and Depression; however it also manages other conditions such as:

- Weight Management – For information about the telephonic Molina Weight Management Program or to enroll members, please contact our Member Assessment Unit.
- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll Members, please contact our Health Management Unit
- Maternity Program - For information about Maternity Program or to enroll members, please contact our OB Prenatal service Unit

Case Management (CM)

Molina provides a comprehensive Case Management (CM) program to all Members who meet the criteria for services.

The CM program focuses on procuring and coordinating the care, services, and resources needed by Members with complex needs through a continuum of care. Molina adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina case managers are licensed professionals and are educated, trained and experienced in the Care Management process. The CM 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 CM program is individualized to accommodate a Member's needs with collaboration and approval from the Member's PCP. The Molina case manager will arrange 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 CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

Referral to Care Management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the CM program. The case manager works collaboratively with all Members of the health care team, including the PCP, hospital UM staff, discharge planners, specialist Providers, ancillary Providers, the local Health Department and other community resources. The referral source provides the case manager with demographic, health care and social data about the Member being referred.

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

- High-risk pregnancy, including Members with a history of a previous preterm delivery
- Catastrophic medical conditions (e.g. neoplasm, organ/tissue transplants)
- Chronic illness (e.g. asthma, diabetes, End Stage Renal Disease)
- Preterm births
- High-technology home care requiring more than two weeks of treatment
- Member accessing ER services inappropriately

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

Phone: (888) 898-7969

Fax: (248) 925-1732

Medical Record Standards

The Provider is responsible for maintaining an electronic or paper medical record for each individual Member. Records are expected to be current, legible, detailed and organized to allow for effective and confidential patient care by all Providers.

Medical records are to be stored in a secure manner that permits easy retrieval. Only authorized personnel may have access to patient medical records.

Providers will develop and implement confidentiality procedures to guard Member protected health information, in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy standards and all other applicable Federal and State regulations. The Provider must ensure his/her staff receives periodic training regarding the confidentiality of Member information.

The Provider is responsible for documenting directly provided services. Such services must include, but not necessarily be limited to, family planning services, preventive services, services for the treatment of sexually transmitted diseases, ancillary services, diagnostic services and diagnostic and therapeutic services for which the Member was referred to the Provider.

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in the Quality section of this Provider Manual. Medical records

shall be maintained in accordance with State and Federal law, and for a period not less than ten (10) years.

Medical Necessity Standards

“Medically Necessary” or **“Medical Necessity”** means health care services that a physician, exercising prudent clinical judgment, would provide to a patient.

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

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

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature.

This literature is 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, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Specialty Pharmaceuticals/Injectables and Infusion Services

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

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 drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the Molina Pharmacy and Therapeutics Committee.

8. Quality

Maintaining Quality Improvement Processes and Programs

Molina maintains a Quality Department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina Quality Department **toll free at (888) 898-7969 or fax (248) 925-1789**.

The address for mail requests is:
Molina Healthcare of Michigan, Inc.
Quality Department
880 W. Long Lake Road, Suite 600
Troy, Michigan 48098

This Provider Manual contains excerpts from the Molina Quality Improvement Program (QIP). For a complete copy of Molina's QIP you can contact your Provider Services Representative or call the telephone number above to receive a written copy.

Molina has established a QIP that complies with regulatory and accreditation guidelines. The QIP provides structure and outlines specific activities designed to improve the care, service and health of our Members.

Molina does not delegate Quality activities to Medical Groups/IPAs. However, Molina requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care and to:

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during Potential Quality of Care and/or Critical Incident investigations; and,
- 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 Primary Care Providers. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and case management/disease management programs and education.

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

Quality of Care

Molina has an established a systematic process to identify, investigate, review and report any potential 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.

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. Providers should maintain medical records to meet the following components:

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

Medical Record Keeping Practices

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

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

Content

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

- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advanced Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Practitioner.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report.
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

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

Retrieval

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina for purposes of Quality Improvement;
- The medical record is available to Michigan Department of Health and Human Services (MDHHS) and the External Quality Review Organization upon request;
- The medical record is available to the Member upon their request;
- A storage system for inactive member medical records which allows retrieval within twenty-four (24) hours, is consistent with State and Federal requirements, and the record is maintained for not less than ten (10) years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than ten (10) years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Molina Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State law in pursuant to court orders or subpoenas;
- Maintain records and information in an accurate and timely manner;
- Ensure timely access by Members to the records and information that pertain to them;
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an 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; and,
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Molina Quality Department **toll free at (866) 449-6828**. See also the Compliance Section of this Provider Manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating specialist (to include OB/Gyn, behavioral health providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on ninety percent (90%) availability for Emergency Services and ninety percent (90%) or greater for all other services. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to Members.

Appointment Access

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

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

Visit Type	Standard Wait Times
Medicaid/Healthy Michigan, Medicare, MMP/Duals, Marketplace	
Primary Care Practitioner	
Office Wait Time	Not to Exceed Forty-Five (45) Minutes
Urgent Visit	Within forty-eight (48) hours
Non-Urgent Routine Care	Within thirty (30) business days of the request
Well Child/Adolescent Preventive Care	Within thirty (30) business days of the request
Adult Preventive Care	Within thirty (30) business days of the request
Health Assessment	Within four (4) to six (6) weeks of the initial request.
Specialty Care Providers	
Acute/Urgent Care	Within three to five (3-5) days of the request.
Routine Care	Within six (6) weeks of the request.
Mental/Behavioral Health	
Non-life Threatening Emergency Care	Within six (6) hours of the request.
Urgent Care	Within forty-eight (48) hours of the request.

Routine Care	Within ten (10) working days of the request.
Call patients forty-eight (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 **toll free at (866) 449-6828**.

Office Wait Time

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

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Molina requires Providers to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang-up and call 911 or go immediately to the nearest emergency room.

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the **Molina Provider Services Department toll free at (855) 322-4077 or TTY/TDD 711**;
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and,

6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

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

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 obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical 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 under the Resources tab on the www.MolinaHealthcare.com website or from your local Molina Quality Department **toll free at (866) 449-6828**.

Monitoring Access for Compliance with Standards

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

Provider network adherence to access standards is monitored via the following mechanisms:

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

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and

determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Additional information on access to care is available under the Resources tab at www.MolinaHealthcare.com website or is available from your local Molina Quality Department toll free at (866) 449-6828.

Quality of Provider Office Sites

Molina has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina continually monitors Member complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days. 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 form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines (as outlined above under “Medical Record Keeping Practices”) and the thresholds for acceptable performance against the criteria. This includes an assessment of:

- Physical accessibility.
- Physical appearance.
- Adequacy of waiting and examining room space.
- Adequacy of medical/treatment record keeping.

Physical Accessibility

Molina evaluates office sites as identified during the compliance/grievance review process 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 physically disabled patients.

Physical Appearance

The site visits includes, but is not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety.

Adequacy of Waiting and Examining Room Space

During the site visit, 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.

Adequacy of Medical Record Keeping Practices

During the site-visit, Molina discusses office documentation practices with the Provider or Provider's staff. This discussion includes a review of the forms and methods used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records. Molina assesses one (1) medical/treatment record for the areas described in the "Medical Record Keeping Practices" section above. To ensure Member confidentiality, Molina reviews a "blinded" medical/treatment record or a "model" record instead of an actual record.

Monitoring Office Site Review Guidelines and Compliance Standards

Provider office sites must demonstrate an overall eighty percent (80%) compliance with the Office Site Review Guidelines listed above. If a serious deficiency is noted during the review but the office demonstrates overall compliance, a follow-up review may be required at the discretion of the Site Reviewer to ensure correction of the deficiency.

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per physician.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with ten (10) or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.

- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Improvement Plans/Corrective Action Plans

If the medical group does not achieve the required compliance with the site review standards and/or the medical record keeping practices review standards, the Site Reviewer will do all of the following:

- Send a letter to the Provider that identifies the compliance issues.
- Send sample forms and other information to assist the Provider to achieve a passing score on the next review.
- Request the Provider to submit a written corrective action plan (CAP) to Molina within thirty (30) calendar days.
- Send notification that another review will be conducted of the office in six (6) months.

When compliance is not achieved, the Provider will be required to submit a written CAP to Molina within thirty (30) calendar days of notification by Molina. The request for a CAP will be sent certified mail, return receipt requested. This improvement plan should be submitted by the office manager or Provider and must include the expected time frame for completion of activities.

Additional reviews are conducted at the office at six (6) month intervals as needed until compliance is achieved. At each follow-up visit a full assessment is done to ensure the office meets performance standards. The information and any response made by the Provider is included in the Provider's permanent credentials file and reported to the Professional Review Committee on the watch status report. If compliance is not attained at follow-up visits, an updated CAP will be required.

Providers who do not submit a CAP may be terminated from network participation. Any further action is conducted in accordance with the Molina Fair Hearing Plan policy.

Advance Directives (Patient Self-Determination Act)

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

Advance Directives are a written choice for health care. There are three (3) types of Advance Directives:

- **Durable Power of Attorney for Health Care:** allows an agent to be appointed to carry out health care decisions.
- **Living Will:** allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.
- **Guardian Appointment:** allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Molina Members (eighteen [18] years old and up) of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

New adult Members or their identified personal representative will receive educational information and instructions on how to access advance directives forms in their Member Handbook, Evidence of Coverage (EOC) and other Member communications such as newsletters and the Molina website. If a Member is incapacitated at the time of enrollment, Molina will provide advance directive information to the Member's family or representative, and will follow up with information to the Member at the appropriate time. All current Members will receive annual notice explaining this information, in addition to newsletter information.

Members who would like more information are instructed to contact Member Services or are directed to the Caring Connections website at <http://www.caringinfo.org/stateaddownload> 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 Law 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 Directives instructions.

Molina will notify the Provider via fax of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directives forms are State specific to meet State regulations.

Molina will look for documented evidence of the discussion between the Provider and the Member during routine Medical Record reviews.

Services to Enrollees Under Twenty-One (21) Years

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

Well Child/Adolescent Visits

Visits consist of age appropriate components including but not limited to:

- comprehensive health and developmental history;
- nutritional assessment;
- height and weight and growth charting;
- comprehensive unclothed physical examination;
- appropriate immunizations;
- laboratory procedures, including lead blood level assessment appropriate for age and risk factors;
- periodic developmental and behavioral screening;
- vision and hearing tests;
- dental assessment and services;
- health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention).

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. Within thirty (30) calendar days of the review, a copy of the review report and a letter will be sent to the medical group notifying them of their results. Performance below Molina's standards may result in a CAP with a request the Provider submit a written corrective action plan to Molina within thirty (30) calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Providers permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs

Molina maintains an active Quality Improvement Program (QIP). The QIP provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management

The Molina Health Management Program provides for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases. For additional information, please see the Health Management heading in the Healthcare Services section of this Provider Manual.

Care Management

Molina's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the Member's needs so they receive the right care, at the right time, and at the right setting. Molina Healthcare Management includes Health Management (HM) and Case Management (CM) programs.

Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that

meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity
- Detoxification and Substance Abuse
- Opioid
- Sickle Cell Disease

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from your local Molina Quality Department **toll free at (866) 449-6828**.

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines.

Diagnostic preventive procedures include but are not limited to:

- Perinatal/Prenatal Care
- Care for children up to twenty-four (24) months old
- Care for children two to nineteen (2-19) years old
- Care for adults twenty to sixty-four (20-64) years old
- Care for adults sixty-five (65) years and older
- Immunization schedules for children and adolescents

- Immunization schedules for adults

All guidelines are updated with each release by USPSTF and are approved by the Quality Improvement Committee. On annual basis, Preventive Health Guidelines are distributed to Providers via www.MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Molina Provider Newsletter.

Cultural and Linguistic Services

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Molina's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

Molina monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Qualified Health Plan (QHP) Enrollee Experience Survey
- Experience of Care and Health Outcomes® (ECHO)
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives
- Quality Rating System

Molina evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract.

The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina Quality staff toll free at (866) 449-6828

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA© HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must

follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. They are the measurement standard for many of Molina's clinical Quality Improvement activities and health improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Experience of Care and Health Outcomes (ECHO®) Survey

Molina obtains feedback from Members about their experience, needs, and perceptions of Members with behavioral health care. 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, and perceived improvement, among other areas.

Qualified Health Plan (QHP) Enrollee Experience Survey

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

The QHP Enrollee Experience Survey was designed to collect accurate and reliable information from consumers about their experience with the health care they received through Health Insurance Marketplace Qualified Health Plans (QHPs).

The survey includes a set of core questions that address key areas of care and service, with some questions grouped to form composites.

QHP Enrollee Survey topics include:

- Access to care
- Access to information
- Care coordination
- Cost
- Cultural competence
- Customer Service
- Doctor communication
- Health promotion

- Plan administration
- Prevention
- Shared decision-making
- Specialized services

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

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

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

Quality Rating System

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

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

Quality ratings are calculated for each eligible QHP product using clinical quality and enrollee experience survey data. Based on results, CMS will calculate and produce quality performance ratings for each health plan on a one to five (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 not limited, to the following domains:

- Clinical Effectiveness
- Patient Safety
- Prevention
- Access
- 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 is properly coding all services provided; and,
- 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 Molina's website and click on Providers. There is a variety of resources, including:

- HEDIS® CPT/CMS-approved diagnostic and procedural code sheets
- A current list of HEDIS® & CAHPS® Star Ratings measures.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA©).

9. Compliance

Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The program also addresses fraud, waste and abuse prevention and detection 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 deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or Law enforcement agency.

Mission Statement

Molina regards health care fraud, waste and abuse as unacceptable, unlawful, and harmful to the provision of quality health care in an efficient and affordable manner. Molina has therefore implemented a program to prevent, investigate, and report suspected health care fraud, waste and abuse in order to reduce health care cost and to promote quality health care.

Regulatory Requirements

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or,
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services,

submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Anti-Kickback Statute – Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other Federal health care programs.

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

Definitions

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

Waste: 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 the Marketplace program.

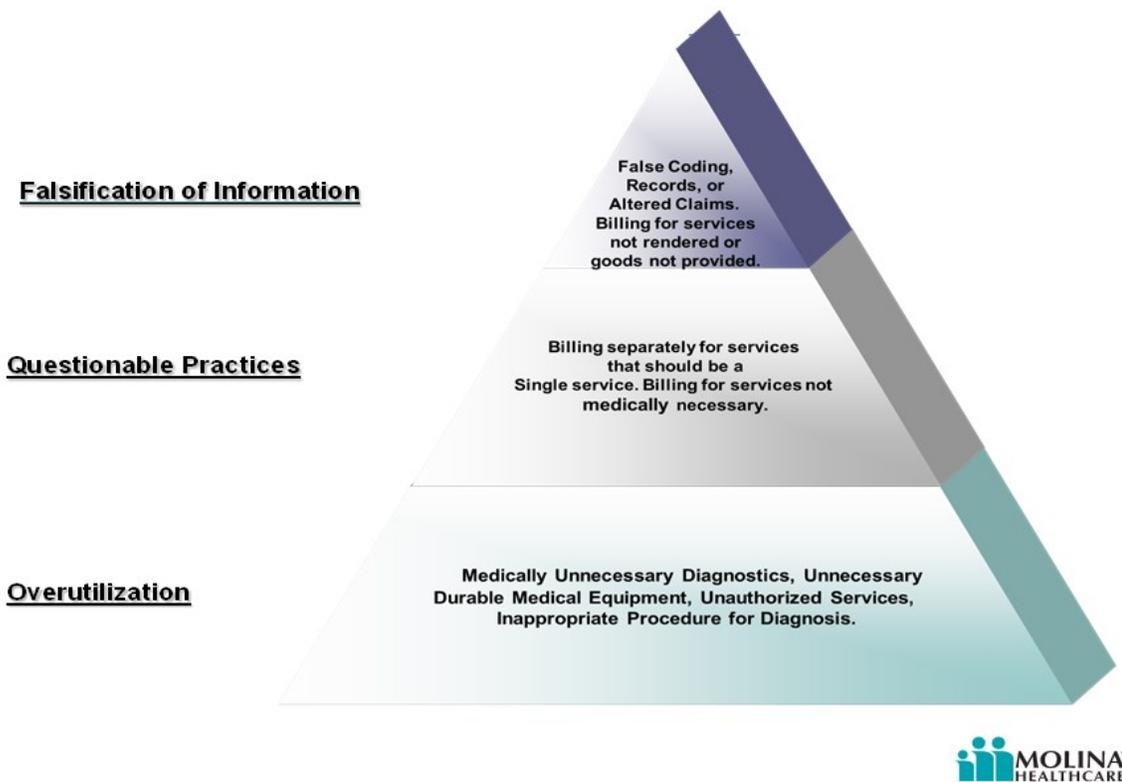
Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Marketplace program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Marketplace 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:

- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Marketplace Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.

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



Examples of Fraud, Waste, and Abuse by a Member

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

- Benefit sharing with persons not entitled to the Member's Marketplace benefits.
- Conspiracy to defraud the Marketplace.
- 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 he/she does not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

Molina Claims Examiners are trained to recognize unusual billing practices and to detect fraud, waste and abuse. If the Claims Examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the Compliance Department.

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

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

Prepayment Fraud, Waste, and Abuse Detection Activities

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

Post-payment Recovery Activities

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

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

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

If a Molina auditor is denied access to Provider's records, all of the claims for which Provider received payment from Molina is immediately due and owing. If Provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. Molina may offset such amounts against any amounts owed by Molina to Provider.

Provider must comply with all requests for documentation and records timely (as reasonably requested by Molina) and without charge to Molina. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

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

Provider Education

When Molina identifies through an audit or other means a situation with a Provider (e.g. coding, billing) that is either inappropriate or deficient, Molina may determine that a Provider education 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 to Molina addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste and Abuse

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

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

You may also report cases of fraud, waste or abuse to Molina's Compliance Department.

You have the right to have your concerns reported anonymously without fear of retaliation.

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

Remember to include the following information when reporting:

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

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

Michigan Department of Health and Human Services
Office of Inspector General
P.O. Box 30062
Lansing, MI 48909
Toll Free Phone: (855) MI-FRAUD

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

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

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

Applicable Laws

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

1. Federal Laws and Regulations

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

2. State Medical Privacy Laws and Regulations.

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

Uses and Disclosures of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity¹. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

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

¹See, 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

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:
 - Quality improvement
 - Disease management
 - Case management and care coordination
 - Training Programs
 - Accreditation, licensing, and credentialing

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

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing Federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

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. A sample Authorization for the Use and Disclosure of Protected Health Information is included at the end of this section.

Patient Rights

Patients are afforded various rights under HIPAA. Molina Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

- 1. Notice of Privacy Practices**
Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.
- 2. Requests for Restrictions on Uses and Disclosures of PHI**
Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.
- 3. Requests for Confidential Communications**
Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.
- 4. Requests for Patient Access to PHI**
Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.
- 5. Request to Amend PHI**
Patients have a right to request that the Provider amend information in their designated record set.
- 6. Request Accounting of PHI Disclosures**
Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI.

As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their

identity –such as health insurance information—without the person’s knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

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

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

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

1. Click on the area titled “I’m a Health Care Professional”
2. Click the tab titled “HIPAA”
3. And then 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. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier

Provider must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA.

The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Molina and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within thirty (30) days and should also be reported to Molina within thirty (30) days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Molina.

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

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



**AUTHORIZATION FOR THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Member Name: _____
Member Address: _____
City/State/Zip: _____

Member ID #: _____
Date of Birth: _____
Telephone #: _____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

Name of persons/organizations authorized to receive the protected health information:

Specific description of protected health information that may be used/disclosed:

The protected health information will be used/disclosed for the following purpose(s):

The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes ___ No ___

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

Molina may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina reserves the right to deny that health care.

I understand that I have a right to receive a copy of this authorization, if requested by me.

I understand that I may revoke this authorization at any time by notifying Molina in writing, except to the extent that:

- action has been taken in reliance on this authorization; or
- if this authorization is obtained as a condition of obtaining health care coverage, other Law provides the Health Plan with the right to contest a Claim under the benefits or coverage under the plan.

I understand that the information I authorize a person or entity to receive may be no longer protected by Federal Law and regulations.

This authorization expires on the following date or event*:

**If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below.*

_____ Signature of Member or Member's Personal Representative	_____ Date
_____ Printed Name of Member or Member's Personal Representative, if applicable	_____ Relationship to Member or Personal Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the Member, if the authorization was sought by Molina

10. Claims and Compensation

As a contracted Provider, it is important to understand how the Claims process works to avoid delays in processing your Claims. The following items are covered in this section for your reference:

- Hospital Acquired Conditions and Present on Admission Program
- Claim Submission
- Coordination of Benefits (COB)/Third Party Liability (TPL)
- Timely Claim Filing
- Claim Edit Process
- Claim Review
- Claim Auditing
- Corrected Claims
- Timely Claim Processing
- Electronic Claim Payment
- Overpayment and Incorrect Payment
- Claims Disputes/Reconsiderations
- Billing the Member
- Fraud and Abuse
- Encounter Data

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. Effective October 1, 2008, CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

- 1) Foreign Object Retained After Surgery
- 2) Air Embolism
- 3) Blood Incompatibility
- 4) Stage III and IV Pressure Ulcers
- 5) Falls and Trauma
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burn
 - Other Injuries

- 6) Manifestations of Poor Glycemic Control
 - Hypoglycemic Coma
 - Diabetic Ketoacidosis
 - Non-Ketotic Hyperosmolar Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
- 7) Catheter-Associated Urinary Tract Infection (UTI)
- 8) Vascular Catheter-Associated Infection
- 9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
- 10) Surgical Site Infection Following Certain Orthopedic Procedures:
 - Spine
 - Neck
 - Shoulder
 - Elbow
- 11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
 - Laparoscopic Gastric Restrictive Surgery
 - Laparoscopic Gastric Bypass
 - Gastroenterostomy
- 12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
- 13) Iatrogenic Pneumothorax with Venous Catheterization
- 14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
 - Total Knee Replacement
 - Hip Replacement

What this means to Providers:

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

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: <http://www.cms.hhs.gov/HospitalAcqCond/>

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 Molina’s Provider Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional

Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID 38334. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member's Molina ID card.

Claims that do not comply with Molina's electronic Claim submission requirements will be denied.

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.

Required Elements

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges for service provided.
- Place and type of service code.
- Days or units as applicable.
- Provider tax identification.
- National Provider Identifier (NPI).
- Rendering Provider as applicable.
- Provider name and billing address.
- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- E-signature.
- Service Facility Location.

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

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Molina as soon as possible, not to exceed thirty (30) calendar days from the change.

Rendering, Ordering, Referring, Attending, Prescribing, and Billing NPI must be enrolled in CHAMPS effective 1/1/2019.

Claims submitted for providers that are not enrolled in CHAMPS for dates of service on or after 1/1/2019 will be rejected.

Electronic Claims Submission

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

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

Molina offers the following electronic Claims submission options:

- Submit Claims directly to Molina via the [Provider Portal](#)
- Submit Claims to Molina via your regular EDI clearinghouse using Payer ID 38334

Provider Portal

Molina's Provider Portal offers a number of claims processing functionalities and benefits:

- Available to all Providers at no cost
- Available twenty-four (24) hours per day, seven (7) days per week
- Ability to add attachments to claims (Portal and clearinghouse submissions)
- Ability to submit corrected claims
- Easily and quickly void claims
- Check claims status
- Receive timely notification of a change in status for a particular claim

Clearinghouse

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

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse

- You should 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 may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@MolinaHealthcare.com for additional support.

Paper Claim Submissions

If electronic claim submission is not possible, please submit paper claims to the following address:

Molina Healthcare
P.O. Box 22668
Long Beach, CA 90801

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

Faxed claims are not accepted by Molina Healthcare and if received, the claim will be returned.

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

For Members enrolled in a Molina Marketplace plan, Molina and/or contracted Medical Groups/IPAs are financially responsible for the care provided to these Members. Molina Marketplace will pay Claims for Covered Services, however if TPL/COB is determined post payment, Molina Marketplace will attempt to recover any Overpayments.

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within 365 calendar days after the discharge for inpatient services or the Date of Service for outpatient services.

If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within thirty (30) to forty-five (45) 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.

Reimbursement Guidance and Payment Guidelines

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

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

- Manuals and RVU files published by the Centers for Medicare and Medicaid Services (CMS), including:
 - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUEs). 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 (NCDs).
 - Medicare Local Coverage Determinations (LCDs).
 - CMS Physician Fee Schedule Relative Value File (RVU) indicators.
- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

Coding Sources

Definitions

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

There are three types of CPT codes:

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

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

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

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

Claim Auditing

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. 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.

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims.

Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

EDI (Clearinghouse) Submission:

837P

- In the 2300 Loop, the CLM segment (claim information) CLM05-3 (claim frequency type code) must indicate one of the following qualifier codes:
 - “1”-ORIGINAL (initial claim)
 - “7”-REPLACEMENT (replacement of prior claim)
 - “8”-VOID (void/cancel of prior claim)
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

837I

- Bill type for UB claims are billed in loop 2300/CLM05-1. In Bill Type for UB, the “1” “7” or “8” goes in the third digit for “frequency”.
- In the 2300 Loop, the REF *F8 segment (claim information) must include the original reference number (Internal Control Number/Document Control Number ICN/DCN).

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider’s contract.

Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within thirty (30) to forty-five (45) days after receipt of Clean Claims.

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

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at www.MolinaHealthcare.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of claim payment, Molina determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a claim for such Overpayment.

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

If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the Provider. Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the Provider receives a payment from Molina that reduces or deducts the Overpayment.

Claim Disputes/Reconsiderations

Providers disputing a Claim previously adjudicated must request such action within thirty (30) to forty-five (45) days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. *The form must be filled out completely in order to be processed.* Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following:

Providers should submit the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number clearly marked on all supporting documents

Forms may be submitted via fax at (248) 925-1768 or the Provider Portal. Claims Disputes/Reconsideration requested via the CRRF.

Submitted via fax: (248) 925-1768

Please Note: Requests for adjustments of Claims paid by a delegated medical group/IPA must be submitted to the group responsible for payment of the original Claim.

The Provider will be notified of Molina's decision in writing within thirty (30) to forty-five (45) days of receipt of the Claims Dispute/Adjustment request.

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. 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 owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
 - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
 - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.
 - The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse

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

Encounter Data

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

Encounter data must be submitted at least once per month, and within three-hundred-sixty-five (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. For institutional services, only those services covered by Molina should be reported.

Molina shall have a comprehensive automated and integrated Encounter data system capable of meeting these requirements.

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

Molina will create Molina's 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When your Encounters are filed electronically you should receive:

- For any direct submission to Molina you should receive a 999 acknowledgement of your transmission
- For Encounter submission you will also receive a 277CA response file for each transaction

11. 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 our Provider Portal located at <https://provider.MolinaHealthcare.com/> or via fax at (248) 925-1768 using the Claim Dispute Request Form. If unable to submit electronically Claim Dispute Request Forms may be sent to the following address:

Molina Healthcare of Michigan
Attention: Provider Inquiry Research and Dispute
880 W. Long Lake Road, Suite 600
Troy, MI 49098

<http://www.MolinaHealthcare.com/providers/mi/medicaid/forms/pages/fuf.aspx>

Claim Dispute Request Form

<https://www.MolinaHealthcare.com/providers/mi/medicaid/forms/PDF/Claim-DisputeAppeal-RequestForm.pdf>

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 our Provider Portal located at <https://provider.MolinaHealthcare.com/> or via fax at (248) 925-1768.

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

Molina Healthcare of Michigan
Attention: Provider Appeals
880 W. Long Lake Road, Suite 600
Troy, MI 49098

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 did not know nor reasonably could have known that patient was a Molina Healthcare 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 Healthcare Services at: (800) 594-7404.
- 2) By phone at telephone (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.

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 ninety (90) 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 Healthcare’s member website at <https://www.MolinaHealthcare.com/providers/mi/medicaid/forms/PDF/medicaid-authorized-representative.pdf>

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

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

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

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.

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: administrative decisions and medical necessity review.

Administrative Denials

Molina has a one (1) level appeal process for the practitioner appeal of post-service administrative denials. An **example of an administrative denial** is failure to authorize services according to required time frames. Retrospective authorization is not a Molina process, except in the event of extenuating circumstances. If a clean claim has not been submitted and an extenuating circumstance exists, these requests should follow the Utilization Management 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 written notification provided within thirty (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 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 must submit a written appeal within ninety (90) calendar days of the initial 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. 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.
- D. The Medical Director or other qualified physician will/may consult with a physician of the same or similar specialty as the case in review.
- E. A decision will be rendered and written notification provided within thirty (30) calendar days of the receipt of a post-service appeal.

Level 2

- A. If you disagree with the decision at Level 1, a practitioner must submit a second written appeal within ninety (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 request must include **additional** supporting documentation justifying the need for the denied service.
- 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 thirty (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 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
Attn: Provider Appeals (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
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, 8:00 to 5:00 p.m. ET. Deaf or hard of hearing Members may call our toll-free TTY 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
Attention: Member Grievances and Appeals
880 West Long Lake Road, Suite 600
Troy, MI 48098
www.MolinaHealthcare.com/Marketplace

Two 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 his/her administrative grievance to Molina by:

- Sending Molina an administrative grievance in writing by mail or filing online at our website.

Our address is:

Molina Healthcare of Michigan

Attention: Member Grievances and Appeals
880 West Long Lake Road, Suite 600
Troy, MI 48098
www.MolinaHealthcare.com/Marketplace

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 thirty-five (35) calendar days 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 thirty-five (35) 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 thirty-five (35) 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 one-hundred-eighty (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 seventy-two (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 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
 Attention: Grievances and Appeals Coordinator
 880 West Long Lake Road, Suite 600
 Troy, MI 48098
 Phone: (888) 560-4087

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

The Member or the Member’s Authorized Representatives must file an appeal within one-hundred-eighty (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 SEVENTY-TWO (72) HOURS.
PRE-SERVICEAUTHORIZATION	WITHIN THIRTY (30) DAYS.
CONCURRENT SERVICE (A REQUEST TO EXTEND OR A DECISION TO REDUCE A PREVIOUSLY APPROVED COURSE OF TREATMENT)	WITHIN SEVENTY-TWO (72) HOURS FOR URGENT CARE SERVICES AND THIRTY (30) DAYS FOR OTHER SERVICES.
POST-SERVICEAUTHORIZATION	WITHIN SIXTY (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 his/her 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
<https://www.michigan.gov/difs>
Phone: (877) 999-6442
Fax: (517) 284-8838

Molina Healthcare of Michigan
880 West Long Lake Road, Suite 600
Troy, MI 48098
Phone: (888) 560-4087
www.MolinaHealthcare.com/marketplace

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 1 (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
<https://www.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 of 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 fourteen (14) days after being assigned the request to review the Adverse Benefit Determination.

The Director of DIFS will notify the Member and Molina of his or her 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 his or her decision within fourteen (14) business days after he or she makes the decision to conduct the review himself or herself. 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, he or she 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 thirty-six (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 twenty-four (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 his or her decision.

Reporting

All Grievance/Appeal data, including Provider specific data, is reported quarterly to Member/Provider Satisfaction Committee by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee (EQIC) quarterly. Annually, a quantitative/qualitative report will be compiled and presented to the Member/Provider Satisfaction Committee (MPSC) and EQIC by the chairman of MPSC to be included in the organization's Grand Analysis of customer satisfaction and assess opportunities for improvement.

Appeals and Grievances will be reported to the State quarterly. Grievance and Appeals reports will be reviewed monthly by the Credentialing Coordinator for inclusion in the trending of ongoing sanctions, complaints and quality issues.

Record Retention

Molina will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via

the core processing system or maintained in other electronic files, Molina will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process.

Provider shall maintain records for a period not less than ten (10) years from the termination of the Model Contract and retained further if the records are under review or audit until the review or audit is complete. (Provider shall request and obtain Health Plan's prior approval for the disposition of records if Agreement is continuous.)

12. Credentialing and Recredentialing

The purpose of the Credentialing Program is to assure the Molina Healthcare and its subsidiaries (Molina) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Molina to provide superior health care to the community.

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

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

Definitions

A Rental/Leased Network - a network of Providers that leases its panel to another network or insurer with an emphasis on expanding Provider access and negotiating discounted fee-for-service fees. This type of network is sometimes referred to as a brokerage-leased network or thought of as "wholesale," since Members' access to the network is through an intermediary.

Primary Care Provider (PCP) – a Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to Pediatricians, Family Providers, General Providers or Internists, as designated by Molina.

General Practitioner – Physicians who are not Board Certified and have not completed a training program from an accredited training program in their requested specialty.

Urgent Care Provider (UCP) - a Provider who is not a PCP and only provides urgent care services to Members. A UCP may include PA, NP, MD and DO. The UCP is usually trained in general practice, internal medicine, family medicine, pediatrics, or emergency medicine. Some UCPs may also have specialty training.

Primary Source verification - the process by which Molina verifies credentialing information directly from the entity that originally conferred or issued the credential to the Provider.

Locum Tenens – a substitute physician used to fill in for a regular physician for reasons such as illness, pregnancy, vacation, or continuing medical education. The regular physician bills and receives payment for the substitute physician as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

Physician – is a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

Unprofessional conduct – refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct, which is reasonably likely to be detrimental to Patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina plan.

Telemedicine – the practice of medicine using electronic communications, information technology, or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional encounter in person between a practitioner and a patient.

Type of Practitioners Credentialed & Recredentialed

Practitioners and groups of practitioners with whom Molina contracts must be credentialed prior to the contract being implemented. These practitioners must be licensed, certified or registered by the state to practice independently.

Providers that are licensed as organizations or facilities will be credentialed as an Organizational Provider (please refer to the policy titled Assessment of Organizational Providers).

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral healthcare practitioners who are licensed, certified or registered by the state to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- 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
- Psychologist
- Speech and Language Pathologists
- Telemedicine Practitioners

Criteria for Participation in the Molina Network

All Practitioner must have active enrollment in the Michigan Medicaid program. Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of Providers for participation in the Molina network. 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 Providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Molina reserves the right to exercise discretion in applying any criteria and to exclude Providers 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 Provider to a hearing or any other rights of review.

Providers must meet the following criteria to be eligible to participate in the Molina network. If the Provider fails to meet/provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

- **Application** - Provider must submit to Molina a complete credentialing application and signed attestation within 180 days. Application must include all required attachments.
- **License, Certification or Registration** - Provider must hold an active, valid and unrestricted 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.
- **DEA or CDS Certificate** - Provider must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Provider must have a DEA or CDS in every State where the Provider provides care to Molina Members.
- **Education and Training** - Providers will only be credentialed in an area of practice in which they have adequate education. Provider must have graduated from an accredited school with a degree in their designated specialty.
 - **Residency Training** - Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing.
 - **Fellowship Training** - If the Provider is not board certified in the specialty in which they practice and has not completed a residency program they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** - Board certification in the specialty in which the Provider is practicing is preferred but not required. Verification of board certification is primary source verified directly with the American Board of Medical Specialties.
- **Work History** - Provider must supply most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional.
- **Malpractice History** - Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application.
- **Professional Liability Insurance** – Provider must supply current professional malpractice liability insurance coverage on application or current copy of certificate. Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria. This coverage shall extend to Molina Members and the provider's activities on Molina's behalf.

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

Burden of Proof

The Provider shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network.

This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a Provider without limitation, including physical and mental health status as allowed by Law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina network. If the Provider fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Providers who fail to provide this burden of proof do not have the right to submit an appeal.

Provider Termination and Reinstatement

If a Provider's contract is terminated and later it is determined to reinstate the Provider, the Provider must be initially credentialed prior to reinstatement, if there is a break in service more than thirty (30) calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Professional Review Committee's review must be re-verified. The Professional Review Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the Provider's reentry into the network. Not all elements require re-verification; for example, graduation from medical school or residency completion does not change. If the contract termination was administrative only and not for cause, if the break in service is less than thirty (30) calendar days, the Provider can be reinstated without being initially credentialed.

If Molina is unable to recredential a Provider within thirty-six (36) months because the Provider is on active military assignment, maternity leave or sabbatical, but the contract between Molina and the Provider remains in place, Molina will recredential the Provider upon his or her return. Molina will document the reason for the delay in the Provider's file. At a minimum, Molina will verify that a Provider who returns has a valid license to practice before he or she can resume seeing Patients. Within sixty (60) calendar days of notice, when the Provider resumes practice, Molina will complete the recredentialing

cycle. If either party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

Credentialing Application

At the time of initial credentialing and recredentialing, the Provider must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the Provider's credentials. The application must be completed in its entirety. The Provider must attest that their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source.

The application must include, unless State law requires otherwise:

- Reason for any inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and,
- The correctness and completeness of the application.

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 or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the Provider specializes. This does not preclude Molina from including in its network Providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Notification of Discrepancies in Credentialing Information

Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license, malpractice claims history or sanctions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law. Please also refer to the section below titled 'Providers Right to Correct Erroneous Information'.

Notification of Credentialing Decisions

A letter is sent to every Provider with notification of the Professional Review Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two (2) weeks of the decision. Copies of the letters are filed in the Provider's credentials files. Under no circumstance will notification letters be sent to the Providers later than sixty (60) calendar days from the decision.

Providers Rights during the Credentialing Process

Providers have the right to review their credentials file at any time. Provider's rights are published in the online Provider Manual for them to review at any time. A copy of the Provider Manual is made available to the Provider at the time of initial contracting.

The Provider must notify the Credentialing Department and request an appointed time to review their file and allow up to seven (7) calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Director will be present. The Provider 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 Provider are documents which the Provider sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Providers may not copy documents that include pieces of information that are confidential in nature, such as the Provider credentialing checklist, the responses from monitoring organizations (i.e. National Provider Data Bank, State Licensing Board), and verification of hospital privileges letters.

Providers Right to Correct Erroneous Information

Providers have the right to correct erroneous information in their credentials file. Providers are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina will notify the Provider immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the Provider. Examples include but are not limited to actions on a license or malpractice claims history.

Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

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

- Their requirement to submit a written response within ten (10) calendar days of receiving notification from Molina.
- In their response, the Provider must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.

- The Provider's response must be sent to Molina Healthcare, Inc. Attention: Credentialing Director, at PO Box 2470, Spokane, WA 99210.

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

The Provider may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

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

Providers Right to be Informed of Application Status

Providers have a right, upon request, to be informed of the status of their application.

The Provider can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two working days. Molina may share with the Provider where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a Provider to review references or recommendations, or other information that is peer-review protected.

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 Member/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

Molina monitors the following agencies for Provider sanctions and exclusions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified.

If a Molina Provider is found to be sanctioned or excluded, the Provider's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

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

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

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

13. Delegation

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

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

Delegation Criteria

Credentialing

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

- Pass Molina's credentialing pre-assessment, which is based on NCQA® credentialing standards.
- Have a multi-disciplinary Professional Review Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against Office of Inspector General (OIG) and System for Award Management (SAM) exclusion lists a minimum of every thirty (30) days.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Agree to Molina's contract terms and conditions for credentialing delegates.
- Submit timely and complete Credentialing delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.
- When key specialists, as defined by Molina, contracted with IPA or group terminate, provide Molina with a letter of termination according to Contractual Agreements and the information necessary to notify affected Members.

Note: If the Provider is an NCQA® Certified or Accredited organization, a modified pre-assessment audit may be conducted. Modification to the audit depend on the type of Certification or Accreditation the Medical Group, IPA, or Vendor has, but will always include evaluation of applicable State requirements and Molina business needs.

If the Provider sub-delegates Credentialing functions, the sub-delegate must be NCQA® accredited or certified in Credentialing functions, or demonstrate and ability to meet all Health Plan, NCQA®, and State and Federal requirements

identified above. A written request must be made to Molina prior to execution of a contract, and a pre-assessment must be made on the potential sub-delegate, and annually thereafter. Evaluation should include review of Credentialing policies and procedures, Credentialing and Recredentialing files, and a process to implement corrective action if issues of non-compliance are identified.

An entity may request Credentialing delegation from Molina through Molina's Delegation Oversight Manager or through their Contract Manager. Molina will ask the potential delegate to submit policies and procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review and approval. Final decision to delegate Credentialing responsibilities is based on the entity's ability to meet Molina, State and Federal requirements for delegation.

Delegation Reporting Requirements

Delegated entities contracted with Molina must submit monthly and quarterly reports determined by the function(s) delegated to the identified Molina Delegation Oversight Staff within the timeline indicated by the Health Plan. For a copy of Molina's current delegation reporting requirements, please contact your Molina Contract Manager.

14. Risk Adjustment Management Program

What is Risk Adjustment?

Risk Adjustment is a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information (age, gender, etc.)

Why is Risk Adjustment Important?

- Allows Molina to focus on quality and efficiency.
- Enables us to recognize and address current and potential health conditions early.
- Identifies Members for Case Management referral.
- Ensures accurate payment for the acuity levels of our Members.
- Most importantly, Risk Adjustment allows Molina to have the resources to deliver the highest quality of care to our Members.

Your Role as a Provider

As a provider your documentation is critical to Risk Adjustment because medical records:

- Are a valuable source of diagnosis data.
- Help determine the ICD-10 codes that should be used.
- Ensure that diagnosis data submitted to State and Federal agencies is accurate.

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

- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only submit codes for which the Provider is certain the Member has.
- Contain a treatment plan.
- Be clear and concise.
- Contain the member's name and date of service.
- Contain the physician's signature and credentials.

RADV Audits

As part of the regulatory process, CMS conducts Risk Adjustment Data Validation (RADV) audits to ensure that diagnosis data submitted by Molina was accurate.

All claims/encounters submitted to Molina are subject to Federal and internal health plan auditing. If Molina is selected for a RADV audit, Providers will be required to provide medical records to validate the data previously submitted.

Contact Information

For further questions about Molina's Risk Adjustment programs, please contact our team at: RiskAdjustment.Programs@MolinaHealthcare.com

15. Glossary of Terms

Advanced Premium Tax Credit (APTC): a tax credit provided by the Federal government that can be used to cover monthly premiums for health coverage purchased through the marketplace. Tax credits are subject to income qualification criteria.

Affordable Care Act: the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the Federal regulations implementing this Law and binding regulatory guidance issued by Federal regulators.

Annual Out-of-Pocket Maximum (also referred to as “OOPM”): is the maximum amount of Cost Sharing that Member’s will have to pay for Covered Services in a calendar year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that Members make toward any Deductibles, Copayments, or Coinsurance.

Amounts that Members pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

- (i) the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
- (ii) the family OOPM will be met when the Member’s family Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual OOPM amount, We will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year. Once the Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, Molina will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family

- **For Individuals** – is the maximum amount of Cost Sharing the Member, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to the EOC are specified in the Schedule of Benefits. For the EOC, Cost Sharing includes payments the Member makes towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, Molina will pay 100% of the charges for Covered Services for the remainder of the calendar year.

- Amounts that the Member pays for services that are not Covered Services under the EOC will not count towards the individual Annual Out-of-Pocket Maximum.
- **For Family (2 or more Members)** – is the maximum amount of Cost Sharing that a family of two or more Members will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to the EOC are specified in the Schedule of Benefits. For the EOC, Cost Sharing includes payments the subscriber or other family members enrolled as Members under the EOC make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by two or more family members enrolled as Members under the EOC reaches the specified Annual Out-of-Pocket Maximum amount, Molina will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that the subscriber or other family members enrolled as Members under the EOC pay for services that are not Covered Services under the EOC will not count towards the family Annual Out-of-Pocket Maximum.

Authorization or Authorized: a decision to approve specialty or other Medically Necessary care for a Member by the Member’s PCP, medical group or Molina. An Authorization is usually called an “approval.”

Benefits and Coverage: (also referred to as “**Covered Services**”) the health care services that Members are entitled to receive from Molina under this Agreement.

Coinsurance: a percentage of the charges for Covered Services Members must pay when they receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina Schedule of Benefits. Some Covered Services do not have Coinsurance and may apply a Deductible or Copayment.

Copayment: a specific dollar amount Members must pay when they receive Covered Services. Copayments are listed in the Molina Schedule of Benefits. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

Cost Sharing: the Deductible, Copayment, or Coinsurance that Members must pay for Covered Services under this Agreement. The Cost Sharing amount Members will be required to pay for each type of Covered Service is listed in the Molina Schedule of Benefits.

Deductible: is the amount the Member must pay in a calendar year for Covered Services the Member receive before Molina will cover those services at the applicable Copayment or Coinsurance. The amount that the Member pays towards the Deductible is based on the rates that Molina has negotiated with the Participating Provider. Deductibles are listed in the Molina Schedule of Benefits.

Please refer to the Molina Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amount. The Member's product may have separate Deductible amounts for specified Covered Services.

If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

When Molina covers services at "no charge" subject to the Deductible and the Member has not met the Deductible amount, the Member must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, the Member will not pay any Deductible or other Cost Sharing towards such preventive services.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If the Member is in a family of two or more Members, the Member will meet the Deductible either:

- i. when the Member meets the Deductible for the individual Member; or
- ii. when the Member's family meets the Deductible for the family.

For example, if the Member reaches the Deductible for the individual Member, the Member will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in the family must continue to pay towards the Deductible until the family meets the family Deductible

A "**Medical Deductible**" in the Silver and Gold Plans applies only to Outpatient Hospital or Facility and Inpatient Hospital or Facility services. It does not apply to outpatient professional services such as doctor office visits.

A "**Prescription Drug Deductible**" applies only to Formulary Non-Preferred Brand Name drugs and Specialty Drugs as described in the Prescription Drug Coverage benefit in the EOC.

When Molina covers services at "no charge" subject to the Deductible and Members have not met their Deductible amount, the Member must pay the charges for the services. When preventive services covered by Molina are included in the Essential Health Benefits, Members will not pay any Deductible or other Cost Sharing towards those preventive services.

A "Combined Medical/Pharmacy Deductible" is waived for Preventive and first three Office visits and Generic Drugs.

Dependent: a Member who meets the eligibility requirements as a Dependent, as described in the Evidence of Coverage.

Drug Formulary: is Molina's list of approved drugs.

Durable Medical Equipment: is medical equipment that serves a repeated medical purpose and is intended for repeated use. It is generally not useful to Members in the absence of illness or injury and does not include accessories primarily for Member comfort or convenience.

Emergency or Emergency Medical Condition: 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 organ or part..

Emergency Services: mean health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

Essential Health Benefits or "**EHB**": a standardized set of essential health benefits that are required to be offered by Molina to Members and their dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

Ambulatory patient care

- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental* and vision care for Members under the age of 19

*Pediatric dental services may be separately provided through a stand-alone dental plan that is certified by the Marketplace.

Experimental or Investigational: any medical service including procedures, medications, facilities, and devices that Molina has determined have not been demonstrated as safe or effective compared with conventional medical services.

FDA: the United States Food and Drug Administration.

Habilitative Services: health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.

These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Facility: an institution providing health care services, including a hospital or other licensed inpatient center; an ambulatory surgical or treatment center; a skilled nursing center; a home health agency; a diagnostic, laboratory or imaging center; and a rehabilitation or other therapeutic health setting.

Marketplace: a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Michigan buy qualified health plan coverage from insurance companies or health plans. The Marketplace may be run as a State-based marketplace, a Federally-facilitated marketplace or a partnership marketplace. For the purposes of this document, the term refers to the Marketplace operating in the State of Michigan, however, it may be organized and run.

Medically Necessary or Medical Necessity: health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not 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 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.

Member: an individual who is eligible and enrolled under the EOC, and for whom Molina has received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is not applying for coverage on their own behalf, but is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under the EOC on behalf of a minor child who, as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for

making the Premium and Cost Sharing payments for the Member and will act as the legal representative of the Member under this product but will not be a Member.

Molina Healthcare of Michigan, Inc. (Molina Healthcare or Molina): the corporation licensed by Michigan as a Health Maintenance Organization, and contracted with the Marketplace.

Non-Participating Provider: refers to those physicians, hospitals, and other Providers that have not entered into contracts to provide Covered Services to Molina Marketplace Members.

Other Practitioner: refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians.

Participating Provider: refers to those Providers, including hospitals and physicians that have entered into contracts to provide Covered Services to Members through this product offered and sold through the Marketplace.

Premiums: mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

Primary Care Doctor (also Primary Care Physician): the doctor who takes care of a Member's health care needs. A Primary Care Doctor may be one of the following types of doctors:

- Family or general practice doctors who usually can see the whole family.
- Internal medicine doctors, who usually only see adults and children 14 years or older.
- Pediatricians, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).

Primary Care Provider or "PCP":

- a Primary Care Doctor, or
- an individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor.

Prior Authorization: means Molina's decision to approve specialty or other Medically Necessary care for a Member before services are provided. A Prior Authorization is sometimes called an "approval" or "authorization."

Service Area: the geographic area in Michigan where Molina has been authorized by the Michigan Department of Health and Human Services to market individual products sold through the Marketplace, enroll Members obtaining coverage through the

Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

Specialist Physician: any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

Spouse: the Subscriber's legal husband or wife.

Subscriber: an individual who is a resident of Michigan, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina.

Subscriber: means either:

1. An individual who is a resident of the plan State, satisfies the eligibility requirements of the EOC, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina in accordance with the terms of the EOC. This includes an individual who is not a minor and is applying on their own behalf for Child-Only Coverage under the EOC; or
2. A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under the EOC on behalf of a minor child, who as of the beginning of the plan year, has not attained the age of 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of the Member under the EOC.

Urgent Care Services: those health care services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.