Managed Medical Assistance/Long-Term Care Provider Handbook
Florida | 2018
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Managed Medical Assistance: Addresses and Phone Numbers

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8:00 AM to 7:00 PM EST/EDT Monday through Friday, excluding State holidays.

<table>
<thead>
<tr>
<th>Member Services</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
</tr>
<tr>
<td>8300 NW 33rd Street, Suite 400</td>
</tr>
<tr>
<td>Doral, FL 33122</td>
</tr>
<tr>
<td>Phone: (866) 472-4585</td>
</tr>
<tr>
<td>TTY: (800) 955-8771 (English)</td>
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Claims Department

The Claims Department is located at our corporate office in Long Beach, CA. Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina’s Provider Portal). All hard copy (CMS-1500, UB-04) claims must be submitted by mail to the address listed below. Electronically filed claims must use EDI Claims/ Payor ID number - 51062.

To verify the status of your claims, please visit the Provider Portal or call our Provider Claims Representatives at the numbers listed below.

<table>
<thead>
<tr>
<th>Claims</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
</tr>
<tr>
<td>PO Box 22812</td>
</tr>
<tr>
<td>Long Beach, CA 90801</td>
</tr>
<tr>
<td>Phone: (855) 322-4076</td>
</tr>
<tr>
<td>TTY: (800) 955-8771 (English)</td>
</tr>
<tr>
<td>(800) 955-8773 (Spanish)</td>
</tr>
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<table>
<thead>
<tr>
<th>Provider Portal</th>
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<tr>
<td><a href="https://provider.molinahealthcare.com">https://provider.molinahealthcare.com</a></td>
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Claims Recovery Department

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

<table>
<thead>
<tr>
<th>Claims Recovery</th>
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<tr>
<td><strong>Address:</strong> Molina Healthcare of Florida (Recovery Lockbox) Atlanta, GA 30374-1037</td>
</tr>
<tr>
<td><strong>Phone:</strong> (866) 642-8999</td>
</tr>
<tr>
<td><strong>Fax:</strong> (888) 396-1121</td>
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</table>

Credentialing Department

The Credentialing Department verifies all information on the Practitioner 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 Healthcare network. The Credentialing Department also performs office and medical record reviews.

<table>
<thead>
<tr>
<th>Credentialing</th>
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<tbody>
<tr>
<td><strong>Address:</strong> Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122</td>
</tr>
<tr>
<td><strong>Phone:</strong> (855) 322-4076</td>
</tr>
<tr>
<td><strong>Fax:</strong> (866) 422-6445</td>
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</table>
Health Line (24-Hour Nurse Advice Line)

This telephone-based nurse advice line is available to all Molina Healthcare 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.

<table>
<thead>
<tr>
<th>HEALTHLINE (24-Hour Nurse Advise Line)</th>
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<tbody>
<tr>
<td>English Phone: (888) 275-8750</td>
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<tr>
<td>Spanish Phone: (866) 648-3537</td>
</tr>
<tr>
<td>TTY: (866) 735-2929 (English)</td>
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<tr>
<th>Healthcare Services Authorization &amp; Inpatient Census</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
</tr>
<tr>
<td>8300 NW 33rd Street, Suite 400</td>
</tr>
<tr>
<td>Doral, FL 33122</td>
</tr>
<tr>
<td>Phone: (855) 322-4076</td>
</tr>
<tr>
<td>Fax: (866) 440-4791</td>
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</table>
Health Education & Health Management Department

The Health Education and Health Management Department provides education and health information to Molina Healthcare Members and facilitates Provider access to the programs and services.

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<th>Health Education &amp; Management</th>
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<td>Address: Molina Healthcare of Florida</td>
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<tr>
<td>8300 NW 33rd Street, Suite 400</td>
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<tr>
<td>Doral, FL 33122</td>
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<tr>
<td>Phone: (855) 322-4076</td>
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<tr>
<td>Fax: (866) 422-6445</td>
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Behavioral Health

Beacon Health Options and Access Behavioral Health manage all components of behavioral health for Molina Healthcare Members.

<table>
<thead>
<tr>
<th>Beacon Health Options</th>
<th>Access Behavioral Health</th>
</tr>
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<tbody>
<tr>
<td><strong>Medicaid Regions 4, 6, 7, 8, 9, and 11</strong></td>
<td><strong>Medicaid Region 1</strong></td>
</tr>
<tr>
<td>Address: Beacon Health Options</td>
<td></td>
</tr>
<tr>
<td>200 State Street</td>
<td></td>
</tr>
<tr>
<td>Boston, MA 02109</td>
<td></td>
</tr>
<tr>
<td>Phone: 1-855-371-3945</td>
<td></td>
</tr>
<tr>
<td>(24) Hours per day, (365) day per year</td>
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</tr>
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</table>

| Address: Access Behavioral Health |
| Attn: Claims Department |
| 1221 W. Lakeview Avenue |
| Pensacola, FL 32501 |
| Phone: 1-866-477-6725 |
| (24) Hours per day, (365) day per year |
Pharmacy Department

Molina Healthcare’s drug formulary requires Prior Authorization for certain medications including injectable medications. The Pharmacy Department can answer questions regarding the formulary and/or drug Prior Authorization requests. They will also facilitate the services of Caremark Pharmacy Services for injectable medications. The Molina Healthcare formulary is available at www.molinahealthcare.com.

<table>
<thead>
<tr>
<th>Pharmacy Authorizations</th>
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<tbody>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>(800) 791-6856</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
<tr>
<td>(866) 236-8531</td>
</tr>
</tbody>
</table>

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 serving all Molina Healthcare of Florida’s provider network.

<table>
<thead>
<tr>
<th>Provider Services</th>
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<tbody>
<tr>
<td>Address:</td>
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<tr>
<td>Molina Healthcare of Florida</td>
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<tr>
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<tr>
<td>Doral, FL 33122</td>
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<tr>
<td>Phone:</td>
</tr>
<tr>
<td>(855) 322-4076</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
<tr>
<td>(866) 948-3537</td>
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</tbody>
</table>
Vision Care

Molina Healthcare is contracted with iCare Solutions to provide routine vision services for our Members. Members who are eligible may directly access a vision care network Provider.

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<thead>
<tr>
<th>iCare Solutions</th>
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<tbody>
<tr>
<td><strong>Address:</strong> iCare Health Solutions</td>
</tr>
<tr>
<td>Attn: Claims</td>
</tr>
<tr>
<td>7352 NW 34th Street</td>
</tr>
<tr>
<td>Miami, FL 33122</td>
</tr>
<tr>
<td><strong>Phone:</strong> (855) 373-7627</td>
</tr>
</tbody>
</table>

Dental Care

Molina Healthcare is contracted with DentaQuest to provide dental services for our Members. Members who are eligible may directly access DentaQuest network Providers.

<table>
<thead>
<tr>
<th>DentaQuest</th>
</tr>
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<tbody>
<tr>
<td><strong>Address:</strong> DentaQuest – Claims</td>
</tr>
<tr>
<td>12121 North Corporate Parkway</td>
</tr>
<tr>
<td>Mequon, WI 53092</td>
</tr>
<tr>
<td><strong>Phone:</strong> (888) 696-9541</td>
</tr>
<tr>
<td><strong>Fax:</strong> (866) 422-6445</td>
</tr>
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</table>
Managed Medical Assistance: Enrollment, Eligibility and Disenrollment

Enrollment in Medicaid Programs

Medicaid is the medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency for Healthcare Administration under s. 409.901 et seq., F.S. It is the state and federal system of health insurance that provides health coverage for eligible children, seniors, disabled adults and pregnant women.

The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: one for Managed Medical Assistance (MMA) and one for Long-Term Care (LTC).

The State of Florida (State) has the sole authority for determining eligibility for Medicaid. The Department of Children and Families acts as the Agency’s agent by enrolling recipients in Medicaid. The agency shall have the sole authority for determining whether Medicaid recipients are required to enroll in, may volunteer to enroll in, may not enroll in a Managed Care Plan or are subject to annual open enrollment. The Agency or its agent(s) shall be responsible for enrollment, including algorithms to assign mandatory potential enrollees, and disenrollment, including determinations regarding involuntary disenrollment, in accordance with this Contract.

The Agency shall be responsible for the operations of the Florida Medicaid Management Information System (FMMIS) and contracting with the state’s fiscal agent to exchange data with Managed Care Plans, enroll Medicaid providers, process Medicaid claims, distribute Medicaid forms and publications, and send written notification and information to all potential enrollees.

Only Medicaid recipients who meet eligibility requirements and are living in a region with authorized Managed Care Plans are eligible to enroll and receive services from the Managed Care Plan. Each recipient shall have a choice of Managed Care Plans and may select any authorized Managed Care Plan unless the Managed Care Plan is restricted to a specific population that does not include the recipient.

The Managed Care Plan may not impose enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider; Indian Health Service; an Indian Tribe, Tribal Organization, or Urban Indian Organization; or through referral under contract health services, in accordance with the American Recovery and Reinvestment Act of 2009.

The Agency or its agents will notify the Managed Care Plan of an enrollee’s selection or assignment to the Managed Care Plan. The Agency or its enrollment broker will send written confirmation to enrollees.
of the chosen or assigned Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer.

Recipients in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan:

1. Temporary Assistance to Needy Families (TANF);
2. SSI (Aged, Blind and Disabled);
3. Hospice;
4. Low Income Families and Children;
5. Institutional Care;
6. Medicaid (MEDS) - Sixth Omnibus Budget Reconciliation Act (SOBRA) for children born after 9/30/83 (age 18 to 19);
7. MEDS AD (SOBRA) for aged and disabled;
8. Protected Medicaid (aged and disabled);
9. Full Benefit Dual Eligibles (Medicare and Medicaid - FFS);
10. Full Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Plans that are not fully liable for all Medicaid services covered under the current SMMC Contract; and
11. The Florida Assertive Community Treatment Team (FACT Team).
12. Title XXI MediKids; and
13. Children between 100 - 133% of federal poverty level (FPL) who transfer from the state’s Children’s Health Insurance Program (CHIP) to Medicaid; and
14. MEDS (SOBRA) for children under one (1) year old and income between 185 - 200% FPL.

**Voluntary Enrollment**

Certain recipients may voluntarily enroll in a Managed Care Plan to receive services. These recipients are not subject to mandatory open enrollment periods.

In addition to the programs and eligibility categories specified, recipients in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan:
1. SSI (enrolled in developmental disabilities home and community based waiver);

2. MEDS AD – (SOBRA) for aged and disabled – enrolled in DD home and community based waiver;

3. Recipients with other creditable coverage excluding Medicare;

4. Recipients age sixty-five (65) and older residing in mental health treatment facilities as defined in s. 394.455(47), F.S.;

5. Residents of DD centers including Sunland and Tachacale;

6. Refugee assistance;

7. Recipients residing in group homes licensed under Chapter 393, F.S.; and

8. Children receiving services in a prescribed pediatric extended care center (PPEC).

**Excluded Populations**

The following Medicaid recipients are not eligible to enroll in a Medicaid Managed Care Plan:

(1) Presumptively eligible pregnant women;

(2) Family planning waiver;

(3) Women enrolled through the Breast and Cervical Cancer Program;

(4) Emergency shelter/Department of Juvenile Justice (DJJ) residential;

(5) Emergency assistance for aliens;

(6) Qualified Individual (QI);

(7) Qualified Medicare beneficiary (QMB) without other full Medicaid coverage;

(8) Special low-income beneficiaries (SLMB) without other full Medicaid coverage;

(9) Working disabled;

(10) Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Dual Special Needs Plans; and

(11) Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Plans that are fully liable for all Medicaid services covered in the current SMMC contract.

(12) Recipients eligible for the Medically Needy program;
In addition, regardless of eligibility category, the following recipients are excluded from enrollment in a Managed Care Plan:

(1) Recipients in the Health Insurance Premium Payment (HIPP) program

**Effective Date of Enrollment**

The Agency or its agents will notify the Managed Care Plan of an enrollee’s selection or assignment to the Managed Care Plan. Notice to the enrollee will be sent by surface mail. Notice to the Managed Care Plan will be by file transfer. Enrollment in the Managed Care Plan shall be effective at 12:01 a.m. on the effective date of enrollment provided on the Enrollment File.

For MMA Managed Care Plans, if the enrollee has not chosen a PCP, the Agency’s confirmation notice will advise the enrollee that a PCP will be assigned by the Managed Care Plan.

Conditioned on continued eligibility, mandatory Members will have a lock-in period of up to (12) consecutive month. After an initial (120) day change period, mandatory Members will only be able to disenroll from the Health Plan for cause. The Agency or its enrollment broker will notify Members at least once every (12) months and at least (60) calendar days prior to the date the lock-in period ends that an open enrollment period exits giving them the opportunity to change Managed Care Plans. Mandatory Members who do not make a change during open enrollment will be deemed to have chosen to remain with the current Managed Care Plan, unless that Managed Care Plan no longer participates. In that case, the Member will be transitioned to a new Managed Care Plan.

Enrollment in a Managed Care Plan may be effective on the first calendar day of the month following an approved plan change.

The Agency will automatically reinstate an enrollee into the Managed Care Plan in which the person was most recently enrolled if the enrollee has a temporary loss of eligibility. In this instance, for mandatory Members, the lock-in period will continue as though there had been no break in eligibility, keeping the original twelve- (12) month period. For MMA Managed Care Plans, the “temporary loss period” is defined as no more than one hundred and eighty (180) calendar days. If a temporary loss of eligibility causes the enrollee to miss the open enrollment period, the Agency will enroll the person in the Managed Care Plan in which he or she was enrolled before loss of eligibility. The enrollee will have one hundred and twenty (120) calendar days from enrollment to disenroll without cause.

**Newborn Enrollment**

Molina Healthcare shall be responsible for newborns of pregnant enrollees from the date of their birth. The Managed Care Plan shall comply with all requirements and procedures set forth by the Agency or its agent related to unborn activation and newborn enrollment.

Failure to comply with the procedures, set forth by the Agency or its agent, related to the unborn activation and newborn enrollment process as specified by the Agency, may result in sanctions.
Newborns are enrolled in the Managed Care Plan of the mother unless the mother chooses another plan or the newborn does not meet the enrollment criteria of the mother’s plan. When a newborn does not meet the criteria of the mother’s plan, the newborn will be enrolled in a plan in accordance with MMA guidelines.

**Inpatient at time of Enrollment**

Regardless of what program or Managed Care Plan the Member is enrolled in at discharge, the Managed Care Plan the Member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility services provided from the date of admission until the date the Member is discharged.

Professional services rendered during the course of an inpatient admission are the responsibility of the Managed Care Plan in which the Member is enrolled on the date of service.

**Eligibility Verification**

**Medicaid Programs**

The Department of Children and Families (DCF) determines eligibility for Medicaid. Eligibility is determined on a monthly basis. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between Providers and Molina Healthcare places the responsibility for eligibility verification on the Provider of services.

**Eligibility Listing for Medicaid Programs**

Providers can verify eligibility for Medicaid Program recipients by calling the Automated Voice Response System (AVRS) at 800-239-7560 or by visiting the fiscal agent’s website at http://mymedicaid-florida.com. When calling to verify a Member’s eligibility, Providers will need their own NPI number AND 10-digit Taxonomy number OR Medicaid Provider ID number. They will also need the Member’s 10-digit recipient number OR Social Security number AND Date of Birth OR 8-digit classic card control number.

Providers may also access recipient’s eligibility information on the Medicaid Eligibility Verification System (MEVS) via the following:

- Provider Self Services Automated voice response (FaxBack) that generates a report with all the eligibility information for a particular recipient, which is automatically faxed to the provider’s fax machine
- Automated voice response that provides eligibility information using a touch-tone telephone
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response

Providers who contract with Molina Healthcare may verify a Member’s eligibility and/or confirm PCP assignment by using the following:
Molina Healthcare Member Services at (866) 472-4585

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A provider should verify a recipient’s eligibility each time the recipient receives services. The verification sources can be used to verify a recipient’s enrollment in a Managed Care Plan. The name and telephone number of the Managed Care Plan are given along with other eligibility information.

Each Medicaid eligible recipient receives an individual identification card from DCF. The recipient is instructed to retain the card even during periods of ineligibility. If the recipient becomes ineligible for Medicaid and later becomes eligible, the same ID card is used.

The Florida Medicaid Identification card is a gold plastic card with a magnetically encoded stripe. Recipients who are eligible for MediKids have a blue and white plastic card with a magnetically encoded stripe.

The provider must submit a claim to the Managed Care Plan using the recipient’s ten-digit Medicaid ID number. This number is not on the Medicaid identification card. The eight-digit number on the front of the Medicaid identification card is the card control number used to access the recipient’s file and verify eligibility. It is not the recipient’s ten-digit Medicaid identification number that is entered on claims for billing.

The provider may obtain this information by looking up the recipient’s eligibility record on MEVS, Faxback, or AVRS using the card control number. The provider should record the recipient’s Medicaid ID number obtained from the eligibility verification for billing purposes. The Medicaid ID number will be included on the valid proofs of eligibility.

All Members enrolled with Molina Healthcare receive an identification card from Molina Healthcare in addition to the Florida Medicaid ID card. Molina Healthcare sends an identification card for each family Member covered under the plan. Members are reminded in their Member Handbooks to carry both ID cards (Molina Healthcare ID card and Florida Medicaid card) with them when requesting medical or pharmacy services. It is the Provider’s responsibility to ensure Molina Healthcare Members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency condition exists, Providers may refuse service if the Member cannot produce the proper identification and eligibility cards.

**Disenrollment**
Molina Healthcare must not restrict the Member’s right to disenroll voluntarily in any way. Neither it, nor its subcontractors, providers or vendors shall provide or assist in the completion of a disenrollment request or assist the Agency’s enrollment broker in the Disenrollment process.
Members requesting disenrollment from Molina Healthcare must be referred to the Agency. Providers should inform Molina Healthcare in writing when a Member has been referred to the Agency's enrollment broker for disenrollment.

**Disenrollment for No Cause**

A mandatory Member subject to open enrollment may submit to the Agency or its enrollment broker a request to disenroll from Molina Healthcare without cause at the following times:

1. During the one hundred and twenty (120) days following the enrollee's initial enrollment, or the date the Agency or its enrollment broker sends the enrollee notice of the enrollment, whichever is later;
2. At least every twelve (12) months during a recipient's annual open enrollment period;
3. During the one hundred and twenty (120) days following the enrollee's re-enrollment if a temporary loss of eligibility causes the enrollee to miss the open enrollment period;
4. When the Agency or its enrollment broker grants the enrollee the right to terminate enrollment without cause (done on a case-by-case basis); and
5. During the thirty (30) days after the enrollee is referred for hospice services in order to enroll in another Managed Care Plan to access the enrollee's choice of hospice provider.

Voluntary enrollees not subject to open enrollment may disenroll without cause at any time.

**Disenrollment for Good Cause**

A mandatory Member may request disenrollment from Molina Healthcare for cause at any time. Such request shall be submitted to the Agency or its enrollment broker. The following reasons constitute cause for disenrollment from Molina Healthcare:

1. The enrollee does not live in a region where the Managed Care Plan is authorized to provide services, as indicated in FMMIS.
2. The provider is no longer with the Managed Care Plan.
3. The enrollee is excluded from enrollment.
4. A substantiated marketing or community outreach violation has occurred.
5. The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
6. The enrollee has an active relationship with a provider who is not on the Managed Care Plan's panel, but is on the panel of another Managed Care Plan. "Active relationship" is defined as having received services from the provider within the six months preceding the disenrollment request.
7. The enrollee is in the wrong Managed Care Plan as determined by the Agency.
8. The Managed Care Plan no longer participates in the region.
(9) The state has imposed intermediate sanctions upon the Managed Care Plan, as specified in 42 CFR 438.702(a)(3).

(10) The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed Care Plan network, or the enrollee’s PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.

(11) The Managed Care Plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(12) The enrollee missed open enrollment due to a temporary loss of eligibility.

(13) Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee’s health care needs; or fraudulent enrollment.

Voluntary enrollees may disenroll from Molina Healthcare at any time.

**Involuntary Disenrollment**

Under very limited conditions and in accordance with Agency guidelines, Members may be involuntarily disenrolled from Molina Healthcare. With proper written documentation and approval by the Agency, the following are acceptable reasons for which Molina Healthcare may submit involuntary disenrollment requests to the Agency or its enrollment broker, as specified by the Agency:

(1) Fraudulent use of the enrollee identification (ID) card. In such cases the Managed Care Plan shall notify MPI of the event.

(2) Falsification of prescriptions by an enrollee. In such cases the Managed Care Plan shall notify MPI of the event.

(3) The enrollee’s behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the Managed Care Plan seriously impairs the organization’s ability to furnish services to either the enrollee or other enrollees.

a) This provision does not apply to enrollees with medical or mental health diagnoses if the enrollee’s behavior is attributable to the diagnoses.

b) An involuntary disenrollment request related to enrollee behavior must include documentation that the Managed Care Plan:

   i. Provided the enrollee at least one (1) oral warning and at least one (1) written warning of the full implications of the enrollee’s actions;

   ii. Attempted to educate the enrollee regarding rights and responsibilities;
iii. Offered assistance through care coordination/case management that would enable the enrollee to comply;

iv. Determined that the enrollee’s behavior is not related to the enrollee’s medical or mental health condition.

Molina Healthcare will not request disenrollment of an enrollee due to:

(1) Health diagnosis;

(2) Adverse changes in an enrollee’s health status;

(3) Utilization of medical services;

(4) Diminished mental capacity;

(5) Pre-existing medical condition;

(6) Uncooperative or disruptive behavior resulting from the enrollee’s special needs (with exceptions);

(7) Attempt to exercise rights under the Managed Care Plan’s grievance system; or

(8) Request of a provider to have an enrollee assigned to a different provider outside of Molina Healthcare’s provider network.

Molina Healthcare will not submit a disenrollment request to be effective later than forty-five (45) days after the Molina’s receipt of the reason for involuntary disenrollment. The Managed Care Plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

Molina Healthcare will send written notification to the enrollee that the Managed Care Plan is requesting disenrollment, the reason for the request, and an explanation that the Molina is requesting that the enrollee be disenrolled in the next Contract month, or earlier if necessary. Until the enrollee is disenrolled, Molina will be responsible for the provision of services to that enrollee.

**PCP Dismissal**

A PCP may dismiss a Member from his/her practice based on standard policies established by the PCP. Reasons for dismissal must be documented by the PCP and may include:

- For a Member who continues not to comply with a recommended plan of health care. Such requests must be submitted at least sixty (60) calendar days prior to the requested effective date.

- For a Member whose behavior is disruptive, unruly, abusive or uncooperative to the extent that the behavior seriously impairs the organization’s ability to furnish services to either the Member or other Members. This Section does not apply to Members with mental health diagnoses if the Member’s behavior is attributable to the mental illness.
Missed Appointments

The provider will document and follow up on appointments missed and/or canceled by the Member. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider’s panel. Such a request must be submitted at least (60) calendar days prior to the requested effective date. The provider agrees not to charge a Member for missed appointments.

A Member may only be considered for an involuntary disenrollment after the Member has had at least one (1) verbal warning and at least one (1) written warning of the full implications of his or her failure of actions. The Member must receive written notification in fourth grade reading level from the PCP explaining in detail the reasons for dismissal from the practice. Action related to request for involuntary disenrollment conditions must be clearly documented by providers in the Member’s records and submitted to Molina Healthcare. The documentation must include attempts to bring the Member into compliance. A Member’s failure to comply with a written corrective action plan must be documented. For any action to be taken, it is mandatory that copies of all supporting documentation from the Member’s file are submitted with the request. Molina Healthcare will contact the Member to educate the Member of the consequences of behavior that is disruptive, unruly, abusive or uncooperative and/or assist the Member in selecting a new PCP. The current PCP must provide emergency care to the Member until the Member is transitioned to a new PCP.

PCP Assignment

Molina Healthcare will offer each Member a choice of PCPs. After making a choice, each Member will have a single PCP. Molina Healthcare will assign a PCP to those Members who did not choose a PCP at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the Member’s last PCP (if the PCP is known and available in Molina Healthcare’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 restrictions. Molina Healthcare will assign all Members that are reinstated after a temporary loss of eligibility to the PCP who was treating them prior to loss of eligibility, unless the Member specifically requests another PCP, the PCP no longer participates in Molina Healthcare or is at capacity, or the Member has changed geographic areas.

Molina Healthcare 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. Molina Healthcare shall assign a pediatrician or other appropriate PCP to all pregnant Members for the care of their newborn babies no later than the beginning of the last trimester of gestation. If Molina Healthcare was not aware that the Member was pregnant until she presented for delivery, it will assign a pediatrician or a PCP to the newborn baby within one (1) business day after birth. Providers shall advise all Members of the Members’ responsibility to notify Molina Healthcare and their DCF public assistance specialists (case workers) of their pregnancies and the births of their babies.
PCP Changes
A Member may change the PCP at any time with the change being effective no later than the beginning of the month following the Member's request for the change. If the Member is receiving inpatient hospital services at the time of the request, the change will be effective the first of the month following discharge from the hospital. The guidelines are as follows:

1. If a Member calls to make a PCP change prior to the 25th of the month, the Member will be allowed to retroactively change their PCP to be effective the first of the current month.

2. If a Member calls to make a PCP change after the 25th of the month, the change will be made prospectively to be effective the first of the following month.

3. If the Member was assigned to the incorrect PCP due to Molina Healthcare’s error, the Member can retroactively change the PCP, effective the first of the current month.
Managed Medical Assistance: Member Rights & Responsibilities

This section explains the rights and responsibilities of Molina Healthcare Members as written in the Molina Member Handbook. Florida law requires that health care providers or health care facilities recognize Member rights while they 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 patients. Members may request a copy of the full text of this law from their health care provider or health care facility. Also included in this section is information about providing interpreter services and advance directives to Molina Healthcare Members.

Molina Healthcare Member Rights & Responsibilities Statement

Members have the right:

- To be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

- To a prompt and reasonable response to questions and requests.

- To know who is providing medical services and who is responsible for his or her care.

- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

- To know what rules and regulations apply to his or her conduct.

- To be given by health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis in a manner appropriate to the member's condition and ability to understand.

- To be able to take part in decisions about his or her health care.

- To have an open discussion about his or her medically necessary treatment options for his or her conditions, regardless of cost or benefit.

- To refuse any treatment, except as otherwise provided by law.

- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

- If he or she is eligible for Medicare, to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
• To receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

• To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, gender identity, or source of payment.

• To treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

• To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

• To receive information about Molina Healthcare, its services, its practitioners and providers and members’ right and responsibilities.

• To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

• To request and receive a copy of his or her medical records, and request that they be amended or corrected.

• To be furnished health care services in accordance with federal and state regulations.

• To make recommendations about Molina Healthcare’s member rights and responsibilities policies

• To voice complaints or appeals about the organization or the care it provides.

• To express grievance regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency listed below:

  Office of Civil Rights
  United States Department of Health and Human Services
  105 W. Adams, 16th Floor
  Chicago, Illinois 60603

  Phone: (312) 886-2359
  TTY: (312) 353-5693

  or

  Bureau of Civil Rights
  Florida Agency of Health Care Administration
  2727 Mahan Drive
  Tallahassee, FL 32308

  Phone: (888) 419-3456
Member Responsibilities

Members have the responsibility for:

- For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
- For reporting unexpected changes in his or her condition to the health care provider.
- For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- To follow the care plan that he or she has agreed on with his or her provider.
- For keeping appointments and, when he or she is unable to do so for any reason, to notify the health care provider or healthcare facility.
- For his or her actions if he or she refuses treatment or does not follow the health care provider’s instructions.
- For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.
- To understand his or her health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
Managed Medical Assistance: Benefits and Covered Services

Molina Healthcare shall provide the services listed below in accordance with the Florida Medicaid Coverage Policy, the Florida Medicaid Coverage and Limitations Handbooks, the Florida Medicaid fee schedules, and the provisions in its contract with the Agency. Molina Healthcare shall comply with all state and federal laws pertaining to the provision of such services. The following provisions highlight key requirements for certain covered services, including requirements specific to the MMA program.

For specific information about a covered service, please contact Member Services at (866) 472-4585.

Covered Services

- Advanced Registered Nurse Practitioner services
- Ambulatory Surgical Center Services
- Assistive Care Services
- Behavioral Health Services
- Birthing Center and Licensed Midwife Services
- Chiropractic Services
- Clinic Services, including Rural health Clinics, Federally Qualified Health Centers, County Health Departments
- Dental Services
- Emergency Services – Refer to Emergency Services section of the handbook for additional information.
- Emergency Behavioral Services
- Family Planning Services and Supplies
- Healthy Start Services
- Hearing Services
- Home Health Services and Nursing Care
- Hospice Services
• Hospital Services – Refer to Hospital Services section of the handbook for additional details
• Immunizations – Refer to Immunization section of the handbook for additional information.
• Laboratory and Imaging Services
• Maternity Services
• Medical Supplies, Equipment, Prostheses and Orthoses
• Nursing Facility Services
• Optometric and Vision Services
• Physician Services
• Physician Assistant Services
• Podiatry Services
• Prescribed Drug Services
• Renal Dialysis Services
• Therapy Services including physical, occupational, speech-language pathology, and respiratory therapies (see Medicaid Therapy Services Coverage and Limitations Handbook and Medicaid Hospital Services Coverage and Limitations Handbook for coverage limitations)
• Transportation
• Well Child Visits - Refer to Well Child Visits section of the handbook for additional information.
## Expanded Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Visits (Non-Pregnant Adults)</td>
<td>Unlimited visits</td>
</tr>
<tr>
<td>Home Health Care (Non-Pregnant Adults)</td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td>Physician Home Visits</td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td>Prenatal/Perinatal Visits</td>
<td>Up to 12 prenatal visits and up to 16 prenatal visits for high-risk pregnancies; subject to prior authorization</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Mammograms and Obstetric ultrasounds costs excluded from accruing towards the Medicaid outpatient services limitation</td>
</tr>
<tr>
<td>Over-The-Counter (OTC) Medication/Supplies</td>
<td>Twenty-five dollars ($25) per head of household per month</td>
</tr>
<tr>
<td><strong>Adult Dental Services</strong></td>
<td>Dental cleaning – twice a year</td>
</tr>
<tr>
<td></td>
<td>Fluoride treatments – twice a year</td>
</tr>
<tr>
<td></td>
<td>X-rays – once a year</td>
</tr>
<tr>
<td></td>
<td>Annual exams – once a year</td>
</tr>
<tr>
<td></td>
<td>Restorative services as follows:</td>
</tr>
<tr>
<td></td>
<td>Fillings – amalgam for 1-2 surfaces (3 per year)</td>
</tr>
<tr>
<td></td>
<td>Fillings - amalgam for 3 surfaces (1 per year)</td>
</tr>
<tr>
<td></td>
<td>Fillings – resin-based composite for 1-2 surfaces (3 per year)</td>
</tr>
<tr>
<td></td>
<td>Fillings – resin-based composite for 3 surfaces (1 per year)</td>
</tr>
<tr>
<td></td>
<td>Emergency dental for pain and infection</td>
</tr>
<tr>
<td>Waived Copayments</td>
<td>Enrollees shall not be subject to co-payment charges for covered services.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
<td>Unlimited eye exams and eyeglasses if medically necessary.</td>
</tr>
<tr>
<td></td>
<td>• A $100 allowance per year for upgraded lenses or frame</td>
</tr>
<tr>
<td></td>
<td>• Upgrade to polycarbonate less (under 21)</td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td>• Newborn hearing screenings,</td>
</tr>
<tr>
<td></td>
<td>• Medically necessary evaluation,</td>
</tr>
<tr>
<td></td>
<td>• Diagnostic testing,</td>
</tr>
<tr>
<td></td>
<td>• Hearing aids</td>
</tr>
<tr>
<td></td>
<td>• Hearing aid fitting and dispensing</td>
</tr>
<tr>
<td></td>
<td>• Hearing aid repair and accessories</td>
</tr>
<tr>
<td><strong>Newborn Circumcision</strong></td>
<td>Available upon request during initial hospitalization</td>
</tr>
<tr>
<td><strong>Adult Pneumonia Vaccine</strong></td>
<td>One (1) vaccination per lifetime</td>
</tr>
<tr>
<td><strong>Adult Influenza Vaccine</strong></td>
<td>One (1) vaccination per year;</td>
</tr>
<tr>
<td><strong>Adult Shingles Vaccine</strong></td>
<td>One (1) vaccination per lifetime</td>
</tr>
<tr>
<td><strong>Post Discharge Meals</strong></td>
<td>Three (3) meals per day for seven (7) days; subject to prior authorization</td>
</tr>
<tr>
<td><strong>Pet Therapy</strong></td>
<td>Unlimited visits; subject to prior authorization</td>
</tr>
<tr>
<td><strong>Art Therapy</strong></td>
<td>Unlimited therapy visits, training, consultations and/or supplies; subject to prior authorization</td>
</tr>
<tr>
<td>Medically Related Lodging and Food</td>
<td>Limited to enrollee and one (1) traveling partner; maximum one hundred and twenty-five dollars ($125) per day when enrollee travels alone; maximum one hundred and sixty-five dollars ($165) per day when enrollee travels with one (1) traveling partner; enrollee must be required to travel more than one hundred and fifty (150) miles from home for medically necessary treatment; overnight stay required; subject to prior authorization</td>
</tr>
</tbody>
</table>

Molina Healthcare will notify affected providers when it makes changes in covered services, including its expanded benefits at least thirty (30) calendar days before the effective date of the change.

In addition to receiving health care services from providers who contract with Molina Healthcare, Members may self-refer and obtain services as listed below:

- Emergency services from any emergency care provider
- Family planning services from any participating Medicaid provider, regardless of whether the provider is a plan provider
- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as Tuberculosis and Human Immunodeficiency rendered by County Health Departments
- Immunizations by County Health Departments
Well Child Visits (formerly CHCUP)

Well Child visits are available to every Medicaid-eligible child under age (21). It includes a comprehensive health and developmental history (including assessment of past medical history, developmental history and behavioral health status); comprehensive unclothed physical examination; developmental assessment; nutritional assessment; appropriate immunizations according to the appropriate Recommended Childhood Immunization Schedule for the United States; laboratory testing (including blood lead testing); health education (including anticipatory guidance); dental screening (including a direct referral to a dentist for enrollees beginning at age three or earlier as indicated); vision screening, including objective testing as required; hearing screening, including objective testing as required; diagnosis and treatment; and referral and follow-up as appropriate. A Well Child visit is a comprehensive, preventive health screening service. Well Child visits are performed according to a periodicity schedule that ensures that children have a health screening on a routine basis. In addition, a child may receive a Well Child visit whenever it is medically necessary or requested by the child or the child’s parent or caregiver. If a child is diagnosed as having a medical problem, the child is treated for that problem through the applicable Medicaid program, such as physician, dental and therapy services.

To provide Well Child visits, a provider must be enrolled in Medicaid as a provider with a Category of Service (code 55) for Well Child Visit.

As licensed health care professionals you are aware that performing a blood test is a federal requirement at specific intervals during the Well Child visit. This note is to remind you how important it is to document the blood tests you are performing in compliance with this federal mandate. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received.

The Well Child schedule listed below is based on the American Academy of Pediatrics, “Recommendations for Preventive Pediatric Health Care” and Florida Medicaid’s recommendation to include the (7) and (9) year old recipients.

Nothing in this handbook waives the EPSDT requirements of 42 U.S.C. § 1396d(r)(5). As such, in accordance with § 1396d(r) and all binding federal precedents interpreting it, Molina must, for Medicaid eligible children under the age of twenty-one (21), pay for any “other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” (42 U.S.C. 1396d(r)(5)) Molina evaluate the medical necessity of the services and will not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for children under the age of twenty-one (21).
The Well Child Visit schedule is:

- Birth;
- 3-5 days for newborns discharged in less than 48 hours after delivery;
- By (1) month;
- (2) months;
- (4) months;
- (6) months;
- (9) months;
- (12) months;
- (15) months;
- (18) months;
- (24) months;
- (30) months;
- Once every year for ages 3-20.

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age (4), then the next periodic screening is performed at age (5).

* Florida Medicaid recommends check-ups at (7) and (9) years of age for those children at risk.
The federal guidelines outlined below specify the minimum requirements included in each Well Child Care (WCC) exam for each of the following age groups; The Well Child Care (WCC) exam (0-18) months is scheduled on a monthly basis, once per year for (2-6) years, and at (7-20) years old. During the Well Child visit visit, providers are required to deliver the following:

<table>
<thead>
<tr>
<th>Well Child Domain</th>
<th>Infants (0-18) months</th>
<th>Children (2-6) years</th>
<th>Adolescents (7-20) years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam and Health History</td>
<td>• History</td>
<td>• History</td>
<td>• History</td>
</tr>
<tr>
<td></td>
<td>• Height</td>
<td>• Height</td>
<td>• Height</td>
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<tr>
<td></td>
<td>• Weight</td>
<td>• Weight</td>
<td>• Weight</td>
</tr>
<tr>
<td></td>
<td>• Physical exam (all of these)</td>
<td>• Physical exam (all of these)</td>
<td>• Physical exam (all of these)</td>
</tr>
<tr>
<td>Development and Behavior Assessment</td>
<td>• Gross motor</td>
<td>• Gross motor</td>
<td>• Social/emotional</td>
</tr>
<tr>
<td></td>
<td>• Fine motor</td>
<td>• Fine motor</td>
<td>• Regular physical activity</td>
</tr>
<tr>
<td></td>
<td>• Social/emotional</td>
<td>• Communication</td>
<td>• Nutritional</td>
</tr>
<tr>
<td></td>
<td>• Nutritional (any one of these)</td>
<td>• Self-help skills</td>
<td>(any one of these)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cognitive skills</td>
<td></td>
</tr>
<tr>
<td>Mental Health Assessment</td>
<td>Mental health (must be addressed)</td>
<td>Mental health (must be addressed)</td>
<td>Mental health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Substance abuse (either one of these)</td>
</tr>
<tr>
<td>Health Education/ Anticipatory Guidance</td>
<td>• Injury prevention</td>
<td>• Injury prevention</td>
<td>• Injury prevention</td>
</tr>
<tr>
<td></td>
<td>• Passive smoking (either one of these)</td>
<td>• Passive smoking</td>
<td>• STD prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(either one of these)</td>
<td>• Smoking/tobacco (any one of these)</td>
</tr>
</tbody>
</table>

Since 2003, Health and Recovery Services Administration (HRSA) has used Health Employer Data Information Set (HEDIS) Well-Child and Well-Adolescent measures to assess the health plans’ rates for the number of children with qualifying Early Periodic Screening Diagnosis and Treatment Program EPSDT exams.

Providers must conduct these regular exams in order to meet the AHCA targeted state standard. When conducting a Well Child exam, please complete AHCA’s Well Child Visit Tracking Form, ensure that the completed form is incorporated into the Member’s medical record.

One of our goals at Molina Healthcare is to improve children’s health, as measured by our Well Child rates. Your help with this effort is essential. If you have questions or suggestions related to Well Child Care regulations, please call our Health Education line at (855) 322-4076.
Vaccines for Children

The Centers for Disease Control and Prevention (CDC), which provides Vaccines for Children (VFC) funding, has developed strict accountability requirements from the state, local health jurisdictions, and individual providers. Molina Healthcare Providers should be enrolled in the VFC program through their local health department.

State supplied vaccines are provided at no cost to enrolled providers through the local health department. Florida is a “universal vaccine distribution” state. This means no fees can be charged to patients for the vaccines themselves and no child should be denied state supplied vaccines for inability to pay an administration fee or office visit.

Molina Healthcare follows AHCA billing guidelines for reimbursing a provider’s administration costs. We reimburse per Florida’s fee schedule. Providers must bill state-supplied vaccines with the appropriate procedure codes.

Immunization Services

Immunization services provide vaccines to induce a state of being immune to or being protected from a disease. Medicaid reimburses these services for recipients from birth through 20 years of age. Molina Healthcare will reimburse simultaneous administration of all vaccines for which an enrollee under the age of twenty-one (21) years is eligible at the time of each visit.

Molina Healthcare will follow only contraindications established by the Advisory Committee on Immunization Practices (ACIP), unless:

- In making a medical judgment in accordance with accepted medical practices, such compliance is deemed medically inappropriate; or

- The particular requirement is not in compliance with Florida law, including Florida law relating to religious or other exemptions.

Molina participating providers must have a sufficient supply of vaccines. Providers that are directly enrolled in the VFC program must maintain adequate vaccine supplies.

Eligible Recipients

Medicaid eligible recipients from birth through eighteen (18) years of age are eligible to receive free vaccines through the federal Vaccine for Children (VFC) Program. The provider is reimbursed only for the administration of the vaccine. The vaccine is free to the provider through the Vaccine for Children (VFC) program, Department of Health.

Title XXI MediKids enrollees do not qualify for the VFC program. Providers must bill Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants.
Medicaid eligible recipients nineteen (19) through twenty (20) years of age may receive vaccines through their health care provider. These vaccines are not free to the provider and are reimbursed by Molina Healthcare. Reimbursement includes the administration fee and the cost of the vaccine.

Upon request by DCF and receipt of the enrollee’s written permission, PCPs are encouraged to provide immunization information about enrollees requesting temporary cash assistance from DCF. This information is necessary in order to document that the enrollee has met the immunization requirements for enrollees receiving temporary cash assistance.

Vaccines for Recipients Birth through (18) Years

For eligible recipients from birth through (18) years of age, vaccines and combination vaccines providing protection against the following diseases are available free to the VFC-enrolled provider through the VFC program:

- Diphtheria, Tetanus and Pertussis (DTaP)
- Haemophilus Influenzae Type b (HIB)
- Hepatitis B (pediatric and adult)
- Meningococcal Conjugate (MCV4)
- Pneumococcal (PCV 7)
- Polio (IPV)
- Measles, Mumps, and Rubella (MMR)
- Tetanus and Diphtheria (Td) (Adult)
- Influenza
- Varicella
- Human Papillomavirus (HPV)
- Rotavirus

The following vaccines are available by request or for high-risk areas only through the VFC program:

- Hepatitis A
- Diphtheria and Tetanus (DT) (Pediatric)
- Pneumococcal Polysaccharide (PPV)
- Meningococcal Polysaccharide (MPSV4)

Vaccines for Recipients (19) through (20) Years

For eligible recipients ages (19) through (20) years, vaccines and combination vaccines providing protection against the following diseases are reimbursable:
• Hepatitis A
• Hepatitis B
• Human Papillomavirus (HPV)
• Influenza
• Measles, Mumps, and Rubella (MMR)
• Meningococcal Conjugate (MCV 4)
• Meningococcal Polysaccharide (MPSV4)
• Pneumococcal Polysaccharide (PPV)
• Tetanus and Diphtheria (Td)
• Varicella

Vaccines for Recipients (21) Years and Older

Medicaid does not cover immunization services for recipients who are (21) years of age and older. However, Molina Healthcare covers the following:

• Influenza, once per year
• Pneumococcal, once per lifetime (subject to prior authorization)
• Herpes Zoster (Shingles), once per lifetime (subject to prior authorization)

Benefit must be accessed at a participating CVS Pharmacy.

Vaccines Excluded from VFC Program

Medicaid may reimburse the cost of the vaccine and an administration fee for all recipients 0-18 years of age who receive vaccines not covered by the VFC program.

Vaccine for Children Program (VFC)

Providers must enroll in the VFC program to receive free vaccines for 0-18 year olds through the VFC program. Information regarding the Vaccine for Children (VFC) Program is available by calling the State of Florida Department of Health, Bureau of Immunization, at 800-4-VFC-KID or 800-483-2543.

Administration Fee Reimbursement

Medicaid reimburses an administration fee to physicians, ARNPs and PAs providing free vaccines through the VFC Program to Medicaid eligible recipients from birth through (18) years of age.

Florida SHOTS

Molina Healthcare is enrolled as a data partner with Florida SHOTS (State Health Online Tracking System). All immunization data is submitted using the process and format specified by AHCA.
Vaccine Reimbursement

Medicaid reimbursement for providing vaccinations to Medicaid-eligible recipients (19-20) years of age includes the cost of the vaccine and an administration fee.

The provider must bill with the appropriate HCPCS procedure code assigned to the vaccine and a modifier HA when appropriate.

Well Child Visits

A Well Child screening is reimbursable in addition to reimbursement for immunizations.

Evaluation and Management Services

Evaluation and management (E&M) services are reimbursable in addition to the administration fee for vaccines, provided the visit is for a separate and identifiable service and the services are documented in the medical record.

Immunization Schedule

Providers should use the current Recommended Childhood Immunization Schedule that is developed and endorsed by the Advisory Committee on Immunization Practices, the Committee on Infectious Diseases of the American Academy of Pediatrics, and Infectious Diseases of the American Academy of Family Physicians. The most recent schedule is available on the Centers for Disease Control website at www.cdc.gov.

Procedure Codes and Fees

See the Physician Services Fee Schedule for the procedure codes and fees. The fee schedules are available on the Medicaid fiscal agent website at:

http://ahca.myflorida.com/medicaid/review/Promulgated.shtml

Urgent Care Services

Urgent care services are covered by Molina Healthcare without a referral.

(24) Hour Nurse Advice Line

Members may call (888) 275-8750 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.

Molina Healthcare 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.

**Telehealth and Telemedicine Services**

You may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. For more information, please refer to Telehealth and Telemedicine services in the definitions section. The following additional provisions that apply to the use of Telehealth and Telemedicine services:

1. Telemedicine services provided under Florida Medicaid must be performed by licensed practitioners within their scope of practice;

2. Telemedicine services must involve the use of interactive telecommunications equipment which includes, at a minimum, audio and video equipment permitting two-way, real time, communication between the enrollee and the practitioner; and

3. Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

When providing services through telemedicine, the Managed Care Plan shall ensure:

1. The telecommunication equipment and telemedicine operations meet the technical safeguards required by 45 CFR 164.312, where applicable;

2. The Managed Care Plan’s providers using telemedicine comply with HIPAA and other state and federal laws pertaining to patient privacy;

3. The Managed Care Plan’s telemedicine policies and procedures comply with the requirements in this Contract; and

4. Provider training regarding the telemedicine requirements in this Contract.

When telemedicine services are provided, the Managed Care Plan shall ensure that the enrollee’s medical/case record includes documentation, as applicable. For more information, please review the **Medical/Case Record Requirements** section of this manual.

Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide services through telemedicine, including telecommunication equipment and services. The enrollee has a choice of whether to access services through a face-to-face or telemedicine encounter.
**Fraud and Abuse Protocols**

If you have been approved by Molina Healthcare to provide services through telemedicine, you are required to have protocols to prevent fraud and abuse. These protocols must address:

(a) Authentication and authorization of users;
(b) Authentication of the origin of the information;
(c) The prevention of unauthorized access to the system or information;
(d) System security, including the integrity of information that is collected, program integrity and system integrity; and
(e) Maintenance of documentation about system and information usage.

**Health Education Programs - Healthy Behaviors**

Molina will offer programs to our members who want to stop smoking, lose weight, or address any drug abuse problems. We will reward members who join and meet certain goals.

The programs include:

- Smoking Cessation Program
- Pediatric Preventive Care
- Weight Loss Programs
- Alcohol or Substance Abuse Program
- Pregnancy Rewards Pregnancy Program
- Adult Access to Preventive and Ambulatory Health Services

**Disease Management Programs**

Molina Healthcare wants providers to be aware of disease management programs offered to assist with care management. The programs that can help providers manage their patient’s condition. These include programs, such as:

- Asthma
- Congestive Heart Failure
- COPD
- CVD
- Diabetes
- Heart Disease
- HIV/AIDS
• Hypertension

A Care Manager/Nurse is on hand to teach your Patient’s about their disease (s). He/she will manage the care with their (PCP) and provide other resources. There are many ways a member can identify to participate in these programs. These programs are not meant to replace or interfere with the member’s physician assessment and care. Our goal is to partner with you in delivering quality healthcare to our members. Members have the option to opt out at any time.

For more info about our programs, please call the Member Services Department at:

(866) 472-4585  
(English) TTY at 1-800-955-8771  
(Spanish) TTY at 1-877-955-8773  
or

Visit www.molinahealthcare.com

Pregnancy Health Management Program

We care about the health of our pregnant members and their babies. Molina’s pregnancy program will make sure member and baby get the needed care during the pregnancy. You can speak with trained Nurses and Care Managers. They can give your office/member the support needed and answer questions you may have. You will be mailed a workbook and other resources are available to the member. The member will also learn ways to stay healthy after child birth. Special care is given to those who have a high-risk pregnancy. It is the member’s choice to be in the program. They can choose to be removed from the program at any time. Molina Health Care is requesting your office to complete the pregnancy notification form (refer to www.molinahealthcare.com for form) and return to us as soon as pregnancy is confirmed. Although pregnancy itself is not considered a disease state, a significant percentage of pregnant females on Medicaid are found to be at moderate to high-risk for a disease condition for the mother, the baby or both. The Pregnancy Rewards SM pregnancy management program strives to reduce hospitalizations and improve birth outcome through early identification, trimester specific assessment and interventions appropriate to the potential risks and needs identified. The Pregnancy Rewards SM does not replace or interfere with the member’s physician assessment and care. The program supports and assists physicians in the delivery of care to members.

Pregnancy Rewards SM Program Activities

Pregnancy Rewards SM Pregnancy Health management Program encompasses clinical case management, member outreach and member and provider communication and education. The Prenatal Case Management staff works closely with the provider community in identification, assessment, and implementation of appropriate intervention(s) for every member participating in the program. The program activities include early identification of pregnant members, early screening for potential risk factors,
provision of telephonic and written trimester appropriate education to all pregnant members and families, referral of high-risk members to prenatal case management, and provision of assessment information to physicians.

**Additional Pregnancy Rewards SM Program Benefits:**

- Prenatal and postpartum care manager follow-up with the patient to ensure that physician and discharge instructions are followed.

- Risk Assessment – An initial health assessment is performed telephonically or via a mailed prenatal screening survey to identify risk factors. Members are stratified to the appropriate level of care, 3 through 4:
  - o Level 3 = Normal pregnancy with no identified risks
  - o Level 2 = High risk pregnancy with risk factors including but not limited to; < age (18) or > (35), Parity > (5), multi-fetal gestation, inter-pregnancy interval of less than (4) to (6) months, BMI > (30), depression, hyperemesis, thyroid disorder, anemia.
  - o Level 3 = High risk pregnancy with risk factors including but not limited to; Alcohol, tobacco or other substance use, past history of an eating disorder, asthma, poor nutrition per initial screening, incompetent cervix, placenta previa, IUGR, pre-eclampsia, hypertension, DVT
  - o Level 4 = High risk pregnancy with risk factors including but not limited to; heart disease, lupus or scleroderma, diabetes, epilepsy, active cancer, ESRD, HIV/AIDS, sickle cell, active psychoses, domestic violence.
  - o Participants identified with a nutritional risk will undergo a comprehensive nutrition assessment and a meal plan developed by a Registered Dietitian.

- Prenatal Case Management – Members assessed at level of care 3 – 4 are contacted via telephone for further intervention and education. A care plan is developed and shared with the physician to ensure that all educational and care needs are met. Prenatal case management registered nurses, in conjunction with the treating physician, coordinate health care services, including facilitation of specialty care referrals, coordination of home health care and DME service and referral to support groups or community social services. The case management data base generates reminders for call backs for specific assessments, prenatal visits, postpartum visits and well-baby checkups.

- Pregnancy newsletters – Educational newsletters are mailed to members each trimester throughout the pregnancy, including the postpartum period.

- Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.

- Member Outreach – Pregnancy Rewards SM Program is promoted to members through various means including, program brochures in new member Welcome Packets, other member mailings, Member
newsletters, Provider newsletters, posters and brochures placed in practitioner’s offices and marketing materials and collaboration with national and local community-based entities.

Health Management Programs

Molina Healthcare’s Health Management programs provide patient education information to Members and facilitate Provider access to these chronic disease programs and services.

Breathe with Ease

Molina Healthcare provides an asthma disease Management program called Breathe with Ease, designed to assist Members in understanding their disease. Molina Healthcare 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.

Breathe with Ease Program Activities

The first component of our program provides general asthma education to all identified asthma Members, including an asthma newsletter. Our goal is to provide Members with a basic understanding of asthma and related concepts, such as common triggers. We also encourage Members to see their PCP regularly for asthma status checks, and important preventive and well-child care.

The second component of our program offers Members identified as having high needs an opportunity to enroll in our more intensive asthma program. We identify these Members through claims and pharmacy data, with a specific focus on ER utilization and inpatient admissions for asthma. Members who choose to participate are sent an asthma kit. The kit currently contains an age-appropriate asthma workbook, video, spacer, magnet with (24) hour nurse advice line phone number, and an allergen-proof pillowcase. Molina Healthcare Members with moderate or severe persistent asthma will also receive a peak flow meter, peak flow diaries and an asthma action plan form to be completed with you in your office.

Additional Asthma Program Benefits:

- Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with asthma. A Registered Nurse (RN) Care Manager calls all patients hospitalized for complications related to asthma. The RN Care Manager completes an assessment of the patient’s medical needs and works with the PCP to resolve concerns. A copy of the assessment is then faxed to the PCP’s office.
- Clinical Practice Guidelines – Molina Healthcare adopted the NHLBI Asthma Guidelines.
- Asthma Registry – Molina Healthcare established an asthma registry. The registry uses available claims and pharmacy information to identify and track asthma Members in the program.
- Asthma Newsletters – Molina Healthcare distributes asthma newsletters to identified Members.
• Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.

• Asthma Profiles – We send PCPs a report or profile of patients with asthma. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare asthma patients not included in the profile.

Healthy Living with Diabetes

Molina Healthcare has a diabetes health management program called Healthy Living with Diabetes designed to assist Members in understanding diabetes and self-care. Molina Healthcare has a special interest in diabetes, as it is the number one chronic diagnosis for our Basic Health Members.

The Healthy Living with Diabetes program includes:

• Hospital Follow-up – Molina Healthcare has a hospital follow-up program for patients with diabetes. An RN Care Manager calls all patients hospitalized for complications related to diabetes. The RN Care Manager completes an assessment of the patient’s medical needs and works with the PCP to resolve concerns. A copy of the assessment is then faxed to the PCP’s office.

• Clinical Practice Guidelines – Molina Healthcare adopted the American Diabetes Association guidelines for diabetic care.

• Diabetes Registry – Molina Healthcare established a diabetes registry. The registry uses available claims and pharmacy information to identify and track diabetic Members in the program.

• Diabetes Newsletters – Molina Healthcare distributes newsletters to diabetic Members.

• Care Reminders and Age-Appropriate Tools – Molina Healthcare provides individualized reminders and educational tools to Members with diabetes.

• Diabetes Education – Diabetes education is covered for all Molina Healthcare Members. We encourage Providers to refer patients to these services, especially for newly diagnosed diabetics or those having difficulty managing their disease.

• Smoking Cessation – For information about the Molina Smoking Cessation Program or to enroll members, please contact our Disease Management Unit.

• Diabetes Profiles – We will send the PCP a report or profile of patients with diabetes. This shows specific patient utilization information of medication use, emergency department visits, and hospitalizations. We also request the PCP provide us with the names of Molina Healthcare diabetic patients not included in the profile.

To find out more information about the disease management programs, please call Member Services Department at (866) 472-4585.
Managed Medical Assistance: Transportation

Non-Emergency Transportation
Molina Healthcare provides Non-Emergency Transportation through Secure Transportation to assist its Members with keeping, and traveling to medical appointments.

To make a reservation for a transportation service, contact Secure's reservation line for Molina Healthcare Members at: (877) 775-7340.

If Member needs further assistance, they can also call (866) 472-4585 and a Member Services Representative will assist them with this request.

Managed Medical Assistance: Provider Responsibilities

Nondiscrimination of Healthcare 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 MMA 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 must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance from a State Medicaid Program.

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711
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 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 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 your information. Please notify your Provider Services Representative or the Provider Services department at: (855) 322-4076 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 to the greatest extent possible.
Molina requires all contracted Providers to participate in and comply with Molina’s Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, health plan access to electronic medical records (EMR), electronic claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA) and registration for and use of Molina’s Provider Web Portal (Provider Portal).

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

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 Web Portal. Providers entering the network as a Contracted Provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network.

**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 Web Portal

**Electronic Claims Submission Requirement**

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

- Ensures 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 Healthcare of Florida via the Provider Portal. See our Provider Web Portal Quick Reference Guide at: [https://provider.molinahealthcare.com](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 51062, refer to our website [www.molinahealthcare.com](http://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) offer a number of claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims including:

- 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

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](http://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 Web Portal**

Providers are required to register for and utilize Molina’s Provider Web Portal (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
• Claims Functions
  o Professional and Institutional Claims (individual or multiple claims)
  o Receive notification of Claims status change
  o Correct Claims
  o Void Claims
  o Add attachments to previously submitted claims
  o Check Claims status
  o Export Claims reports
• Prior Authorizations/Service Requests
  o Create and submit Prior Authorization Requests
  o Check status of Authorization Requests
  o Receive notification of change in status of Authorization Requests
• View HEDIS® Scores and compare to national benchmarks

**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.

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 Rights and Responsibilities**
Providers are required comply with the Member Rights and Responsibilities as outlined in Member materials (such as Member Handbooks). More information 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 MMA 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 Enrollment, Eligibility and Disenrollment section of this Manual.

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
Molina Healthcare’s policies allow only certain lab tests to be performed in a physician’s office regardless of the line of business. All other lab testing must be referred to an In-Network Laboratory Provider. Molina’s In-Network Laboratory providers are certified, full service laboratories, offering comprehensive test menus that include routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the physician’s office is found on the Molina website at www.molinahealthcare.com.

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 may be compensated in accordance with your agreement with Molina Healthcare, when applicable state and federal billing and payment rules and regulations allow.

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

Referrals
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) unless the situation is one involving the delivery of Emergency Services. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document referrals that are made in the patient’s medical record. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

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

Effective February 1, 2018, PCPs are requested to utilize a Referral Form when referring a Member to an in-network specialist for consultation and treatment.

The Molina In-Network Referral Form is found on the Molina website at: www.molinahealthcare.com.

Note: As long as the PCP has made a referral, using the Molina referral form is not required. However, Specialists must maintain evidence that the PCP has made such referral, i.e.: a script or an internal referral form from the PCP office.

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.

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.

Pregnancy Notification Process
The PCP shall submit to Molina the Pregnancy Notification Form (available at www.molinahealthcare.com) within one (1) working day of the first prenatal visit and/or positive pregnancy test of any Member presenting themselves for healthcare services.

The form can be faxed to Molina at (866) 440-9791 or submitted via secure email to: mflbaby@molinahealthcare.com.

**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 Healthcare 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 Improvement section of this 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 Improvement 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 (hard copy or electronic) 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 Health Information and HIPAA Transactions**

Molina requires that its contracted 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.

**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 or statement if needed. This includes the maintenance and retention of Member records for a period of not less than ten (10) years, and retained further if the records are under review or audit until such time that the review or audit is complete.

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.
This includes providing prompt responses to Molina’s 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.

**Laboratory Services**

Participating providers are required to submit laboratory specimens to Quest Diagnostics, Molina’s exclusive provider of laboratory services. This requirement ensures that laboratory services are provided by a credentialed laboratory in the most cost-effective manner, and ensures that Molina has access to laboratory data needed to measure performance quality and outcomes related to HEDIS.

Additionally, Molina allows only certain laboratory tests needed for immediate diagnosis and treatment to be performed in the physician’s office. Please refer to the **In Office Laboratory Tests** section of this manual for more information. All other medically necessary laboratory testing must be directed to Quest by the ordering physician. Claims for laboratory tests performed in the physician office, but not included in “In Office Tests” list will be denied.

Quest is a certified, full service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology.

For more information about testing available through Quest, or for a list of Quest drawing stations, visit [www.questdiagnostics.com](http://www.questdiagnostics.com).

**Healthy Start Provider Requirements**

**Florida's Healthy Start Prenatal Risk Screening**

Molina Healthcare providers must offer Florida's Healthy Start prenatal risk screening to each pregnant member as part of her first prenatal visit. When conducting the Prenatal Risk-Screening, Molina providers must:

- Use the Department of Health-approved Healthy Start (Prenatal) Risk Screening Instrument.
- Keep a copy of the completed screening instrument in the member’s medical record and provide a copy to the member.
• Submit the Healthy Start (Prenatal) Risk Screening Instrument to the CHD in the county where the prenatal screen was completed within ten (10) business days of completion of the screening.

**Florida's Healthy Start Infant (Postnatal) Risk Screening Instrument**

Florida hospitals electronically file the Healthy Start (Postnatal) Risk Screening Instrument Certificate of Live Birth with the CHD in the county of birth within five (5) business days of the birth.

For birthing facilities not participating in the Department of Health electronic birth registration system, required birth information must be filed with the CHD within five (5) business days of the birth. The provider must keep a copy of the completed Healthy Start (Postnatal) Risk Screening Instrument in the member's medical record and mail a copy to the member.

**Ineligible Members**

Pregnant members or infants who do not score high enough to be eligible for Healthy Start case management may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:

• If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score; or

• If the determination is made subsequent to risk screening, the provider may refer the member or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as Human Immunodeficiency Virus (HIV), Hepatitis B, substance abuse or domestic violence.

All infants, children under the age of five (5), and pregnant, breast-feeding and postpartum women will be referred to the local WIC office. Molina Healthcare providers must provide:

• A completed Florida WIC program medical referral form with the current height or length and weight (taken within sixty (60) days of the WIC appointment);

• Hemoglobin or hematocrit; and

• Any identified medical/nutritional problems.

Providers must coordinate with the local WIC office to provide the above referral data from the most recent Well Child visit. For every WIC referral form completed, the provider must give a copy of the form to the member and keep a copy in the member's medical record.

**HIV Testing**
Molina Healthcare providers must offer all women of childbearing age HIV counseling and HIV testing at the initial prenatal care visit and again at twenty-eight (28) and thirty-two (32) weeks. If the member declines an HIV test, providers must obtain a signed objection.

Providers must offer counseling to all pregnant members who are HIV positive and the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services.

**Hepatitis B Testing**

All pregnant members receiving prenatal care must be screened for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit. A second HBsAg test must be conducted between twenty-eight (28) and thirty-two (32) weeks of pregnancy for all members who tested negative at the first prenatal visit, and are considered high risk for Hepatitis B infection.

Any HBsAg-positive women shall be reported to the local CHD and to Healthy Start, regardless of their Healthy Start screening score.

Infants born to HBsAg-positive members shall receive Hepatitis B Immune Globulin (HBIG) and the Hepatitis B vaccine once they are physiologically stable preferably within 12 hours of birth, and shall complete the Hepatitis B vaccine series according to the vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States. Infants born to HBsAg-positive members must be tested for HBsAg and Hepatitis B surface antibodies (anti-HBs) six (6) months after the completion of the vaccine series for success or failure of the therapy. Any child age 24 months or less (<24) who tests positive for HBsAg must be reported to the local CHD within twenty-four (24) hours of the positive test results.

Infants born to members who are HBsAg-positive shall be reported to the local CHD and Healthy Start regardless of their Healthy Start screening score.

Molina Healthcare providers must report all prenatal or postpartum members who test HBsAg-positive to the Perinatal Hepatitis B Prevention Coordinator at the local CHD utilizing the Practitioner Disease Report Form (DH- 2136).

Reporting must include the following information:

- Name
- Date of birth
- Race/Ethnicity
- Address
- Infants
- Contacts
- Laboratory test(s) performed and date the sample was collected
- The due date or estimated date of confinement,
- Whether the member received prenatal care, and
- Immunization dates for infants and contacts
Prenatal Care

Molina Healthcare providers must include the following in all prenatal care:

- A pregnancy test and a nursing assessment with referrals to a physician, PA or ARNP for comprehensive evaluation;
- Referral to care coordination/case management according to the needs of the member;
- Any necessary referrals and follow-up;
- Schedule return prenatal visits at least every four (4) weeks until week thirty-two (32), every two (2) weeks until week thirty-six (36), and every week thereafter until delivery, unless the member’s condition requires more frequent visits;
- Contact those members who fail to keep their prenatal appointments as soon as possible, and arrange for their continued prenatal care;
- Assist members in making delivery arrangements, if necessary;
- Refer pregnant members to appropriate maternity and family services, including notifying medical service payers of member status for further eligibility determination for the member and unborn infant; and
- Screening of all pregnant members for tobacco use and make certain that the providers make available to pregnant members smoking cessation counseling and appropriate treatment as needed.

Nutritional Assessment/Counseling

Providers must provide nutritional assessment and counseling to all pregnant members and ensure the following:

- The provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes;
- Offer a mid-level nutrition assessment;
- Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or physician; and
- Documentation of the nutrition care plan in the medical record by the person providing counseling.

Obstetrical Delivery

Molina Healthcare uses generally accepted and approved protocols for both low-risk and high-risk deliveries, including Healthy Start and prenatal screening. For high risk pregnancies, OB care during labor and delivery must include preparation for symptomatic evaluation and member progression through the final stages of labor and postpartum care.
Preterm delivery risk assessments must be documented in the member’s medical record by week twenty-eight (28).

**Newborn Care**

Molina Healthcare providers must supply the highest level of care for newborns beginning immediately after birth. Such level of care must include, but not be limited to:

- Instilling of prophylactic eye medications into each eye of the newborn;
- When the mother is Rh negative, securing a cord blood sample for type Rh determination and direct Coombs test;
- Weighing and measuring of the newborn;
- Inspecting the newborn for abnormalities and/or complications;
- Administering one half (.5) milligram of vitamin K;
- APGAR scoring
- Any other necessary and immediate need for referral in consultation from a specialty physician, such as the Healthy Start (postnatal) infant screen; and
- Laboratory screenings to test for metabolic, hereditary and congenital disorders known to result in significant impairment of health or intellect, in accordance with s. 383.14, F.S.

These required laboratory tests shall be processed through the State Public Health Laboratory. Molina will reimburse for these screenings at the established Medicaid rate or specified contracted rate.

**Postpartum Care**

For postpartum members, Molina Healthcare providers must:

- Provide a postpartum examination for the member within six (6) weeks after delivery;
- Ensure that its providers supply voluntary family planning, including a discussion of all methods of contraception, as appropriate; and
- Ensure that continuing care of the newborn is provided through the Well Child Care program component and documented in the child’s medical record.
Managed Medical Assistance: 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 or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds 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) 322-4076.

Nondiscrimination of Healthcare 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 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 must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance from a State Medicaid Program.

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

**Molina Institute for Cultural Competency**

Molina is committed to reducing healthcare disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina founded the Molina Institute for Cultural Competency, which 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 training modules.

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

1. Written materials;
2. On-site cultural competency training delivered by Provider Services Representatives;
3. Access to enduring reference materials available through Health Plan representatives and the Molina website; 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, and aids and services that are congruent with cultural norms. Molina supports Members with disabilities, and assists 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 with 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 (Group 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 2010

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 (866) 472-4585. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a 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. 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 notification of his or her right to have a qualified interpreter at no cost.

Members with Hearing Impairment

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), 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 with hearing impairment. Requests should be made three 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.
Managed Medical Assistance: Provider Notifications
Providers will immediately notify Molina Healthcare of Florida, if any of the following events occur:

- Provider’s business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina Healthcare of Florida Community Plus member, or any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim
- Provider is the subject of any criminal investigation or proceeding
- Provider is convicted for crimes involving moral turpitude or felonies
- Provider is named in any civil claim that may jeopardize Provider’s financial soundness
- There is a change in provider’s business address, telephone number, ownership, or Tax Identification Number
- Provider’s professional or general liability insurance is reduced or canceled
- Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours
- Any material change or addition to the information submitted as part of provider’s application for participation with Molina Healthcare of Florida Community Plus
- Any other act, event or occurrence which materially affects provider’s ability to carry out its duties under the Provider Services Agreement

Managed Medical Assistance: PCP Responsibilities

- Coordinate and supervise the delivery and transition of care to for each assigned Member.
- Ensure newly enrolled Members receive an initial health assessment no later than one-hundred eighty (180) days following the date of enrollment and assignment to the PCP.
- Ensure 24/7/365 availability for members requiring emergency services.
- Ensure appointment access for all Members in accordance with the Access to Care Standards
- Provide Well Child Visits in accordance with the periodicity schedule referenced in the Well Child Visits section of this handbook.
- Provide immunizations in accordance with the Recommended Childhood Immunization
- Schedule for the US, or when necessary for the Member’s health.
- Participate in the Vaccines for Children Program (VFC) for Members 18 years old and younger.
- Provide immunization information to the Department of Children and Families (DCF) upon request by DCF and receipt of the Member’s written permission, for members requesting temporary cash assistance.
• Provide adult preventive care screenings in accordance with the U.S. Preventive Services Task Force guidelines
• Utilize Molina Healthcare network providers whenever possible. If services necessary are not available in network, contact Utilization Management for assistance.
• Maintain a procedure for contacting non-compliant Members.
• Ensure Members are aware of the availability of non-emergency transportation and assist members with transportation scheduling.
• Ensure Members are aware of the availability of free, oral interpretation and translation services, including Members requiring services for the hearing impaired.
• Provide a physical screening within seventy-two (72) hours, or immediately if required, for children taken into protective custody, emergency shelter, or foster care program by DCF.
• Submit timely, complete and accurate encounters for each visit where the PCP sees the Member.
• Submit encounters on a CMS-1500 form.
• Allow access to Molina Healthcare or its designee to inspect office, records, and/or operations when requested.
• Cooperate in investigations, reviews or audits conducted by Molina Healthcare, AHCA, or any other state or federal agency.

Site and Medical Record-Keeping Practice Reviews
Molina Healthcare has a process to ensure the offices of all PCPs, OB/Gyns and high volume behavioral health Providers meets Molina Healthcare office-site standards. Molina Healthcare assesses the quality, safety and accessibility of office sites where care is given. Standards and thresholds for office site criteria, medical treatment and record-keeping practices have been approved by Molina Healthcare’s Professional Review Committee (PRC). The site and medical record-keeping review is conducted prior to the initial credentialing decision. The PRC considers site and medical record-keeping review reports with other criteria and information about the Provider when making initial credentialing/re-credentialing determinations.

New Providers joining a contracted medical group reviewed and found to be 80% or more in compliance with Molina Healthcare site review guidelines will not require another site review. A copy of the medical group’s site and medical record-keeping practices review report will be filed in the Provider’s credentials file and reviewed by the PRC as part of the initial credentialing process.

A standard site-visit survey form is completed at the time of each visit. This form includes the Site and Medical Record Keeping Practice Guidelines outlined below and the thresholds (3 or more complaints) for acceptable performance against the criteria. This includes an assessment of:

• Physical accessibility
• Physical appearance
• Adequacy of waiting-room and examining-room space
• Availability of appointments
• Adequacy of medical/treatment record keeping
• Respond to complaints

Adequacy of Medical Record-Keeping Practices

During the site visit, Molina Healthcare discusses office documentation practices with the Provider or Provider’s staff. This discussion includes a review of the forms and a method used to keep the information in a consistent manner and includes how the practice ensures confidentiality of records.

Molina Healthcare assesses medical/treatment records for orderliness of record and documentation practices. To ensure Member confidentiality, Molina Healthcare reviews a blinded medical/treatment record or a model record instead of an actual record.

Improvement Plans/Corrective Action Plans

Within (30) calendar days of the review, a copy of the site review report and a letter will be sent to the medical group notifying them of their results. If the medical group does not achieve the required compliance with the site review standards, the Site Review Nurse (SRN) will do all of the following:

1. Send a letter to the Provider that identifies the compliance issues.
2. Send the Provider helpful information such as forms on which to document problems or medication allergies in the medical record.
3. Request the provider to submit a written corrective action plan to Molina within (30) calendar days.
4. Send notification that another review will be conducted of the office in six months.

When compliance is not achieved, the provider will be required to submit a written Corrective Action Plan (CAP) to Molina Healthcare within (30) calendar days of notification by Molina Healthcare. 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. The SRN conducts additional site reviews of the office at six-month intervals until compliance is achieved. The information and any response made by the provider is included in the providers permanent credentials file and reported to the PRC 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 Molina Healthcare’s policy.

Relocations and Additional Sites

Providers should notify Molina Healthcare (60) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office will be conducted before the Provider’s re-credentialing date.
Compliance Standards
Provider sites must demonstrate an overall 80% compliance with the site and medical record-keeping practice guidelines listed below. 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 Review Nurse to ensure correction of the deficiency.

Site and Medical Record-Keeping Practice Guidelines

Facility
- Molina Healthcare conducts medical record review at all PCP sites that serve (10) or more members.
- Each practice site may be reviewed during each (2) year period or will be reviewed at least (1) time every (3) year period.
- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis 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.

Safety
- 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 Cardio Pulmonary Resuscitation (CPR) certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (Fire, Safety, Blood-Borne Pathogens, etc.) is documented for offices with ten 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.

Administration & Confidentiality
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A Clinical Laboratory Improvement Amendments 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 injectable and emergency medication is checked monthly for outdates.
• Drug refrigerator temperatures are documented daily.

Medical Record-Keeping Practices
• Each patient has a separate medical record. Records are stored away from patient areas and preferably locked. Records are available at each patient visit. Archived records are available within (24) hours.
• Pages are securely attached in the medical record. Computer users have individual passwords.
• Medical records are organized by dividers or color-coding when the thickness of the record dictates.
• A chronic problem list is included in the record for all adults and children.
• Allergies (and the lack of allergies) are prominently displayed at the front of the record.
• A complete health history questionnaire or History & Physical is part of the record.
• Health Maintenance forms includes dates of preventive services.
• A medication sheet is included for chronic medications.
• Advance Directives discussions are documented for those (18) years and older.
• Record-keeping is monitored for Quality Improvement and Health Insurance Portability and Accountability Act (HIPAA) compliance.

Medical Record Documentation
Molina Healthcare requires medical records be maintained in a manner that is current, detailed, organized and permits effective, confidential patient care and quality review. Molina Healthcare has a process to assess and improve, as needed, the quality of medical record-keeping.

At the time of re-credentialing, Molina Healthcare conducts a medical record review of PCPs. Guidelines have been reviewed and approved by the PRC. The PRC considers medical record review reports with other criteria and information about the Provider when making credentialing determinations.

Medical Records are reviewed to assure the following is reflected:
• All services are provided directly by a Provider
• All ancillary services and diagnostic studies are ordered by a Provider
• All diagnostic and therapeutic services for which a Member was referred by a Provider, such as:
  o Home health nursing reports
  o Specialty physician reports
  o Hospital discharge reports
  o Physical therapy reports
Telemedicine/Telehealth Providers
All records shall contain documentation to include the following items for services provided through telemedicine:

1. A brief explanation of the use of telemedicine in each progress note;
2. Documentation of telemedicine equipment used for the particular covered services provided; and
3. A signed statement from the enrollee or the enrollee’s authorized representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided.

Medical Record Retention
Medical records must be maintained for a period not less than ten (10) years from the close of the Provider Services Agreement, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Molina Healthcare if the Provider Services Agreement is continuous.

Confidentiality of Medical Records
Molina Healthcare Members have the right to full consideration of privacy concerning their medical care. Members are also entitled to confidential treatment of all communications and records. Case discussion, consultations, examinations, and treatments are confidential and should be conducted with discretion. Written authorization from the Member or authorized legal representative must be obtained before medical records are released to anyone not directly connected with the care, except as permitted or required by law.

Confidential Information is defined as any form of data, including but not limited to, data that can directly or indirectly identify individual Members by character, conduct, occupation, finances, credit, reputation, health, medical history, mental or physical condition, or treatment. Conversations, whether in a formal or informal setting, e-mail, faxes and letters are also potential sources of confidential information.

All participating Providers must implement and maintain an office procedure that will guard against disclosure of any confidential information to unauthorized persons. The office staff must receive periodic training in confidentiality of member information. This office procedure and training should include the following:

- Written authorization must be obtained from the Member or legal representative before medical records are made available to anyone not directly connected with the care, except as permitted or required by law.
- All signed authorizations for release of medical information received must be carefully reviewed for any limitations to the release of medical information.
• Only the portion of the medical record specified in the authorization should be made available to the requester and should be separated from the remainder of the Member’s medical record.

Site Review Nurse (SRN)

A registered nurse with training and experience in quality improvement and ambulatory care evaluates the Provider’s medical records using Molina Healthcare approved guidelines and audit tools.

Compliance Standards

Providers must demonstrate an overall 80% compliance with the medical record documentation guidelines listed below. A standard medical record review survey form is completed at the time of each visit. This form includes the Medical Record Documentation Guidelines outlined below and the thresholds for acceptable performance of these criteria. At least 5 to10 records per site is a generally-accepted target, though additional reviews must be completed for large group practices or when additional data is necessary in specific instances. Medical records are evaluated for the following:

• Medical record content includes: problem list, allergies, history, diagnosis, and treatment plan based on diagnosis
• Medical record organization
• Information filed in medical records
• Ease of retrieving medical records
• Confidential patient information

Medical Record Documentation Includes:

• Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children (eight and younger), past medical history related to prenatal care, birth, operations and childhood illnesses.

• Significant illnesses and medical conditions are indicated on the problem list. If the patient has no known chronic problems, this is appropriately noted in the record.

• Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies, this is appropriately noted in the record.

• A working diagnosis is recorded with the clinical findings. SOAP charting format is recommended, but not mandatory when progress notes are written.

• Evidence the patient is not being placed at inappropriate risk by a diagnostic or therapeutic procedure.

• Treatment plans are consistent with diagnoses.

• Referral pattern appears appropriate. Review for under and over utilization.

• Notes from consultants are in the record.
• An immunization record for children is up to date. Appropriate history has been made in the medical record for adults.

• Evidence that preventative screenings and services are utilized in accordance with Molina Healthcare’s practice guidelines.

• Patient name and identifying number is on each page of the record.

• The registration form or computer printout contains address, home and work phone number, employer and marital status. An emergency contact should also be designated.

• Staff and provider notes signed with initials or first initial, last name and title.

• Dated entries.

• Records legible to staff in the office other than the provider. Dictation is preferred.

• Appropriate notation concerning tobacco exposure for children of all ages and the use of alcohol, tobacco and substance abuse for patients’ (12) years and older. Query history of abuse by the time the patient has been seen three or more times.

• Pertinent history for presenting problem is included.

• Pertinent physical exam for the presenting problem.

• Lab and other diagnostic tests are ordered as appropriate by the provider.

• Documentation regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or as needed. Include the next preventive care visit when appropriate.

• Previous unresolved problems are addressed in subsequent visits.

• Initials of ordering provider on all reports.

• Explicit follow-up plans for all consults and abnormal lab/imaging results.

• Documentation of appropriate health promotion and disease prevention education.

• Anticipatory guidance is documented at each well child visit.

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 following documentation:

- Identifying information of the member including name, Member identification number, date of birth, sex and legal guardianship (if applicable)
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications (or notation that none are known)
- Include all services provided. Such services must include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Document referral services in enrollees' medical/case records
- Dated and signed entries by the appropriate party
- The chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider including behavioral health conditions
- Studies ordered (e.g., laboratory, x-ray, EKG) and referral reports
- Indicated therapies administered and prescribed including dosages and dates of initial or refill prescriptions
- Name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider
- Disposition, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services
- An immunization history
- Information relating to the Member’s use of tobacco products and alcohol/substance abuse
- Summaries of all Emergency Services and Care and Hospital discharges with appropriate medically indicated follow up
- Reflection of the primary language spoken by the member and any translation needs of the member
- Identification of member’s need for communication assistance in the delivery of health care services
- Copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of thirteen (13).
- Documentation that the Member was provided with written information concerning the member’s right regarding Advance Directives (end of life wishes DNR do not resuscitate), written instructions for wills, living wills or advance directives and health care powers of attorney) and whether or not the member has executed an Advance Directive. Neither Molina Healthcare nor any of its Providers shall, as a condition of treatment, require the member execute or waive an Advance Directive.
- A release document for each Member authorizing Molina Healthcare to release medical information for facilitation of medical care

**Newborn Notification Process**

Physicians must notify Molina Healthcare immediately after the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services.

The PCP or Specialist shall submit the Pregnancy Notification Report Form to Molina Healthcare immediately after the first prenatal visit and/or positive pregnancy test of any member presenting themselves for healthcare services. Providers shall enter all applicable information on the form. The form should be submitted to Molina Healthcare’s Pregnancy Rewards Fax Line (866) 440-9791, or via email to MFLBaby@MolinaHealthcare.com.

**Reporting Abuse, Neglect and Exploitation**

All Molina Healthcare direct service providers must complete Abuse, Neglect, and Exploitation Training. This training may be provided by the Department of Children and Families, the local area agency on aging, the Department of Elder Affairs, or through licensing requirements.

“Abuse” means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee’s physical, mental, or emotional health. Abuse includes acts and omissions.

“Exploitation” of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult’s funds, assets, or property for the benefit of someone other than the vulnerable adult.

2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.

“Neglect” of an adult means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and behavioral health of the vulnerable adult,
including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of the vulnerable adult. The term “neglect” also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. “Neglect” is repeated conduct or a single incident of carelessness that produces, or could reasonably be expected to result in, serious physical or psychological injury or a substantial risk of death.

“Neglect” of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment when such deprivation or environment causes the child’s physical, behavioral, or emotional health to be significantly impaired or to be in danger of being significantly impaired.

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, (800) 96ABUSE. Additionally, providers must report adverse incidents including events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents to Molina Healthcare no more than twenty-four (24) hours of the incident.

The Critical Incident Form is located on Molina Healthcare’s website at:

http://www.molinahealthcare.com/providers/fl/medicaid/forms/Pages/fuf.aspx

To report a critical incident, provider should email the Critical Incident Form to:

MFLQIAalerts@MolinaHealthCare.com

Identifying Victims of Human Trafficking

For specific information regarding indications of Human Trafficking, please refer to the Florida Department of Children and Families at:

http://www.dcf.state.fl.us/programs/humantrafficking/docs/InformationKit.pdf

Member Information and Marketing

Any written informational and marketing materials directed at Molina Healthcare Members must be developed at the fourth grade reading level and have prior written consent from Molina Healthcare and the appropriate government agencies. Please contact your Provider Services Representative for information and review of proposed materials.

Contracted Providers may not:

• Offer marketing/appointment forms.

• Make phone calls or direct, urge or attempt to persuade recipients to enroll in the Managed Care Plan based on financial or any other interests of the provider.
• Mail marketing materials on behalf of the Managed Care Plan.
• Offer anything of value to induce recipients/enrollees to select them as their provider.
• Offer inducements to persuade recipients to enroll in a Managed Care Plan.
• Conduct health screening as a marketing activity.
• Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.
• Distribute marketing materials in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications).
• Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

Contracted Providers may:
• Provide the names of the Managed Care Plans with which they participate.
• Make available and/or distribute Managed Care Plan marketing materials outside of an exam room.
• Providers are permitted to make available and/or distribute Managed Care Plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates.
• Providers may distribute printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract. However, the Managed Care Plan shall ensure that:
  i. Materials do not “rank order” or highlight specific Managed Care Plans and include only objective information.
  ii. Such materials have the concurrence of all Managed Care Plans involved in the comparison and are approved by the Agency prior to distribution.
  iii. The Managed Care Plans identify a lead Managed Care Plan to coordinate submission of the materials.

Providers are also permitted to display posters or other materials in common areas such as the provider’s waiting room.

If a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates.
• Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.

• To the extent that a provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.

• Share information with patients from the Agency’s website or CMS’ website.

• Announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).

• Make new affiliation announcements within the first thirty (30) calendar days of the new provider agreement.

• Make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.

Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.

Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.

**Managed Medical Assistance: Medical Management**

Molina Healthcare Providers must ensure Members receive medically necessary health care services in a timely manner without undue interruption. The Member’s PCP is responsible for:

• Providing routine medical care to Molina Healthcare Members
• Following up on missed appointments
• Prescribing diagnostic and/or laboratory tests and procedures
• Coordinating Referrals and obtaining Prior Authorization when required

This section on Referrals, Authorizations, and Utilization Management (UM) describes procedures that apply to directly contracted Molina Healthcare providers. All contracted providers must obtain Molina Healthcare’s Authorization for specific services that require prior approval.

**Utilization Management – Prior Authorization Process**

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, MCG (formerly known as Milliman Care Guidelines), Interqual®, other third party guidelines, CMS guidelines, state guidelines, 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/concurrent review, or retrospectively.

**Referral versus Prior Authorization**

Referrals are made when medically necessary services are beyond the scope of the PCP’s practice or when complications or unresponsiveness to an appropriate treatment regimen necessitates the opinion of a Specialist. In referring a patient, the PCP should forward pertinent patient information/findings to the Specialist.

Specialists may refer Members to other Specialists or for ancillary services. Referrals and authorizations do not have to be routed back through the PCP.

Generally, prior authorization requirements are designed to assure the medical necessity of service, prevent unanticipated denials of coverage, ensure participating Providers are utilized and all services are provided at the appropriate level of care for the Member’s needs.

Molina Healthcare’s Prior Authorization guidelines and Service Request Form are available on our website at:

http://www.molinahealthcare.com/medicaid/providers/fl/forms/Pages/fuf.aspx

A hard copy of the Prior Authorization Guide and Service Request Form are furnished to all participating providers upon credentialing and when revised, or upon request from a provider.

Providers should send requests for prior authorizations to the Utilization Management Department by phone or fax based on the urgency of the requested service. Contact information is listed below.

**Molina Healthcare Utilization Management Department**

**Phone: (855) 322-4076**

**Fax: (866) 440-9791**

Providers are encouraged to use the Molina Healthcare Service Request Form. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

- Member demographic information (name, date of birth, social security number, etc.)
- Provider demographic information (referring Provider and referred Specialist)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (Diagnosis Code and description)
- Clinical indications necessitating service or Referral
- Pertinent medical history and treatment, laboratory data, and/or physical exams that address the area of request
- Location where the service will be performed
- Requested length of stay (inpatient requests)

Providers may also submit authorization requests through Molina Healthcare’s Web Portal at: [www.molinahealthcare.com](http://www.molinahealthcare.com).

Pertinent data and information is required by the HCS staff to enable a thorough assessment for medical necessity and assign appropriate diagnosis and procedure codes to the authorization. Authorization is based on verification of Member eligibility and benefit coverage at the time of service. Claims payment is contingent on eligibility for date of service and appropriate coding and limitations.

Molina Healthcare will process any non-urgent requests within fourteen (14) working days after receiving adequate clinical information. Urgent requests will be processed within (72) hours. If a Referral has been previously approved, the Specialist or vendor may call Molina Healthcare directly to request an extension of services. Information generally required to support the decision-making process includes:

- Adequate patient history related to the requested services
- Physical examination that addresses the area of the request
- Supporting lab and/or X-ray results to support the request
- Relevant PCP and/or Specialist progress notes or consultations
- Any other relevant information or data specific to the request

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 Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (855) 322-4076.

**Wrong Site Surgery**

If it is determined a wrong site surgery was performed, Molina Healthcare will not reimburse the Providers responsible for the error. Molina Healthcare will immediately report these types of events that are identified as Critical Incidents to AHCA in addition to reporting a summary on a quarterly basis.

**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 Healthcare does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Molina Healthcare never provides financial incentives to encourage HCS decision makers to make determinations that result in under-utilization.

Also, we require our delegated medical groups/IPAs and subcontractors to avoid this kind of conflict of interest.

**Coordination of Care**

Molina Healthcare’s Utilization Management, Case Management and Disease Management will work with Providers to assist with coordinating services and benefits for Members with complex needs and issues. 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.

Molina Healthcare 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 Healthcare staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

**Continuity of Care**

Molina Healthcare Members involved in an active course of treatment have the option to complete treatment with the Provider who initiated care. The lack of a contract with the Provider of a new Member or terminated contracts between Molina Healthcare and a Provider will not interfere with this option.

Molina Healthcare will notify Members in active care at least 60 days before the termination date of the provider and allow Members to continue receiving services from the terminated provider for a minimum of 60 days after the termination date. Continuation of care may not exceed six (6) months after the termination date of the provider.

Molina shall continue the entire course of treatment with the recipient’s current provider for the following services which may extend beyond sixty (60) days continuity of care period:

- Prenatal and postpartum care
- Transplant services
- Oncology (Radiation and/or Chemotherapy services from the current round of treatment)
- Full course of therapy Hepatitis C treatment drugs

Pregnant Members who have initiated a course of prenatal care may continue to receive care from a terminated provider through the completion of pregnancy and postpartum period, regardless of the trimester in which care was initiated.

Requests for continued care should be submitted to the Utilization Management Department at:
Continuity of Care may not apply if a provider is terminated for cause.

**Continuity and Coordination of Provider Communication**

Molina Healthcare 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.

**Case Management**

Molina Healthcare 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 issues through a continuum of care. Molina Healthcare adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Molina Healthcare case managers are licensed Registered Nurses (RNs) and are educated, trained and experienced in the case 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 Healthcare case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina Healthcare 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 Case Management: Members with high-risk medical conditions 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 case management and should be referred to the Molina Healthcare 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
• Children with Special Health Care Needs

Referrals to the Case Management program may be made by contacting Molina Healthcare at:

   Phone: (855) 322-4076  
   Fax: (866) 440-9791

**PCP Responsibilities in Case 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 case management plan. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

**Case Manager Responsibilities**

The case manager collaborates with 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 Education and Disease Management Programs**

Molina Healthcare’s Health Education and Disease Management programs will be incorporated into the Member’s treatment plan to address the Member’s health care needs. Primary prevention programs may include smoking cessation and wellness.

**Emergency Services**
Emergency services are covered twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (365) days a year, for all Members experiencing an emergency medical situation, and do not require authorization.

*Please refer to section Managed Medical Assistance: Hospitals for additional information on Emergency Services.*

Molina Healthcare provides Utilization Management during business hours and a (24) hour Nurse Triage option on the main telephone line for post business hours. In addition, 911 information is given to all Members at the onset of any call to the Plan.

**Medical Necessity Standards**

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered to meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs
- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the Member, the Member’s caretaker, or the provider

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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.

Molina has processes for authorization of any medically necessary service to enrollees under the age of twenty-one (21), in accordance with Section 1905(a) of the Social Security Act, when:

1. The service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook (as found on the AHCA website), Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or

2. Is not a covered service of the plan; or
(3) The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Such services should be requested using the standard processes and should include any and all medical necessity support documentation.
Managed Medical Assistance: Quality Improvement

Molina Healthcare 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 identified goals are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Quality Improvement Program Goals

- Design and maintain programs that improve the care and service outcomes within identified Member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data.
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, Member safety and service.
- Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to Members.
- Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process, and outcomes.
- Using feedback from stakeholders, improve reporting methods to make information available, relevant and timely.
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals, improve organizational communication and ensure participation of contracted community providers in clinical aspects of programs and services.
- Facilitate organizational efforts to achieve and maintain regulatory compliance and to continually review practices to ensure compliance with standards and contractual requirements.
- Identify and track adverse or critical incidents and review and analyze adverse or critical incidents to identify and address/eliminate potential and actual quality of care and/or health and safety issues.
The QIP assists in achieving these goals through an evaluation process of both clinical and service outcomes measuring the effectiveness of internal processes and active improvement interventions. The QIP outlines several functional aspects of the QIP that contributes to a high level of clinical and service quality.

- Health Management Programs; Breathe with Ease for Asthma, Healthy Living with Diabetes, Pregnancy Rewards high risk pregnancy program
- Preventive Care and Clinical Practice Guidelines
- Measurement of Clinical and Service Quality; HEDIS, CAHPS® (Consumer Assessment of Health plan Survey), Provider Satisfaction Survey, and Key Quality Metrics

**Preventive Care and Clinical Practice Guidelines**

This section provides an overview of adopted clinical practice guidelines for Molina Healthcare. All clinical practice guidelines are based on scientific evidence, review of medical literature, or appropriate established authority as cited. All recommendations are based on published consensus guidelines and do not favor any treatment based solely on cost consideration.

The recommendations for care are suggested as guidelines for making clinical decisions. Providers and their patients must work together to develop individual treatment plans tailored to the specific needs and circumstances of each patient.

Molina Healthcare has standard clinical practice guidelines in the following areas:

- Depression – Adopted from the American Psychiatric Association
- ADHD – Adopted from the American Psychiatric Association
- Asthma – Adopted from the new NHLBI Asthma Guidelines by the Florida State Medical Association, in conjunction with community asthma provider
- Cardiovascular – ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in Adults, ATPIII Guidelines for High Blood Cholesterol, Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) and the AHA/ACC Guidelines for Preventing Heart Attack and Death in Patients With Atherosclerotic Cardiovascular Disease: 2001 Update
- COPD – The Global Initiative for Chronic Obstructive Lung Disease guidelines for COPD care
- Diabetes Mellitus – Adopted from the American Diabetes Association Clinical Practice Guidelines
- Preventive Care and Pregnancy Guidelines – Based on recommendations from the U.S. Preventive Services Task Force

On the Molina Healthcare website you will also find information regarding:

- Preventive Screening, Immunization and Counseling Guidelines
• Pregnancy Guidelines
• Well Child Forms (formerly known as CHCUP)
• Immunization Schedules
• Educational tools for patients
• Educational tools for your office

Guidelines are reviewed annually and updated as appropriate. If you would like a printed copy of the guidelines, you may request it by calling our Health Education Line at (855) 322-4076.

**Access to Care Standards:**

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Appointment</td>
<td>Within 30 days of request</td>
</tr>
<tr>
<td>Routine Sick Visit</td>
<td>Within 7 days of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Triage and treat immediately</td>
</tr>
<tr>
<td></td>
<td>Available by phone 24 hours/7 days</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>Available by phone 24 hours/7 days</td>
</tr>
<tr>
<td>Office Waiting Time</td>
<td>Should not exceed 30 minutes</td>
</tr>
</tbody>
</table>

**Measurement of Clinical and Service Quality:**

• Health Employer Data Information Set (HEDIS)
• Consumer Assessment of Health Plans Survey (CAHPS®)
• Provider Satisfaction Survey
• Effectiveness of Quality Improvement Initiatives

**HEDIS**

Molina Healthcare utilizes NCQA HEDIS as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS is conducted annually 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, appropriate use of asthma medications, and prenatal and postpartum care.
HEDIS results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare’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. These activities include Molina Healthcare’s diabetic and asthma health management programs, childhood and adolescent well-child and immunization program, and prenatal and postpartum care programs.

Selected HEDIS results are provided to (HRSA) as part of our contract Health plans also submits results directly to NCQA, consistent with the original intent of HEDIS – to provide health care purchasers data with which to make informed decisions. The data is also used by NCQA to establish health plan performance benchmarks and are an integral part of the NCQA health plan accreditation process.

Your office may be requested to submit documentation from medical files as part of the HEDIS data collection process.

**CAHPS®**

CAHPS® is the tool used by NCQA to summarize Member satisfaction with health care, including Providers and health plans. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Providers Communicate, Courteous and Helpful Office Staff, and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected adult Members. In even-numbered years, HRSA also sponsors a Medicaid CAHPS® survey specific to the care provided to pediatric Members.

CAHPS® survey results are used in much the same way as HEDIS results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina Healthcare’s quality improvement activities and are used by external agencies and health care purchasers to help ascertain the quality of services being delivered.

**Provider Satisfaction Survey**

Recognizing that HEDIS and CAHPS® both focus on Member experience with health care Providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey in the fall of each year. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods we use to identify improvement areas pertaining to the Provider network. The survey results have helped establish improvement activities relating to Molina Healthcare’s specialty network, inter- provider communications, and pharmacy authorizations. This survey is conducted by an external vendor and is sent to a statistically valid, random sampling of Providers each year. If your office is selected to participate, please take a few minutes to complete it and send it back.

**Effectiveness of Quality Improvement Initiatives**

Molina Healthcare 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 a best practice. The Clinical Quality Improvement Committee (CQIC), which includes Members from the Provider network, evaluates clinical metrics on an ongoing basis. Results of these measurements guide activities for the successive periods.

Clinical Metrics include but are not limited to the following:

- Clinical Practice Guideline Compliance measurement:
  - HEDIS measures for asthma, diabetes, and chlamydia screening
  - Use of short-acting beta-agonists for Members with asthma
  - Follow-up Chlamydia testing after positive result and treatment
  - Use of antibiotics for upper respiratory disease

- Effectiveness of interventions in breathe with ease, Healthy Living with Diabetes, Heart Healthy Living, Chronic Obstruct Pulmonary Disease (COPD) programs:
  - Post-hospital follow-up rate with PCP or Specialist
  - Inpatient and emergency department utilization
  - Readmission after primary diagnosis of asthma, diabetes, COPD or a cardiovascular condition
  - Key clinical metrics including but not limited to: annual hemoglobin A1C and eye exams for diabetics and beta-blocker use and cholesterol testing after an acute cardiac event

- Service Improvement Metrics include but are not limited to:
  - UM authorization turnaround times
  - Pharmacy authorization turnaround times
  - Member Services response time
  - Satisfaction with Molina Healthcare specialty network (as measured through CAHPS® and Provider Satisfaction Survey)

Preventive Health, Health Education and Incentive Programs

Molina Healthcare integrates Health Education and Health Management Program goals with HEDIS Effectiveness of Care and Access rate improvement efforts. Member incentives continue to be successfully utilized to encourage Members to access important care and services.

Contracted Providers and Facilities must allow Molina Healthcare 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.

If you have any questions regarding these programs, please call our Health Education Line at (855) 322-4076.
Quality Enhancement Program

Molina Healthcare provides Quality Enhancements that are accessible to our Members in community settings and will collaborate with community agencies/organizations to offer services when possible.

Information regarding the Quality Enhancement programs is distributed to Molina Healthcare members and practitioners through a variety of mechanisms, including but not limited to new practitioner orientation materials, provider handbooks, member handbooks and the Molina Healthcare website.

Molina Healthcare offers Quality Enhancements (QE) to enrollees as specified below:

A. Molina Healthcare shall offer QEs in community settings accessible to enrollees.

B. Molina Healthcare shall provide information in the enrollee and provider handbooks on the QEs and how to access related services.

C. Molina Healthcare, Inc. shall develop and maintain written policies and procedures to implement the QEs.

D. Molina Healthcare may cosponsor the annual training of providers, provided that the training meets the provider training requirements for the programs listed below. Molina Healthcare, Inc. is encouraged to actively collaborate with community agencies and organizations, including CHDs, local Early Intervention Programs, Health Start Coalitions and local school districts in offering these services.

E. If the health plan involves the enrollee in an existing community program for purposes of meeting the QE requirement, the health plan shall ensure documentation in the enrollee’s medical record of referrals to the community program and follow up on the enrollee’s receipt of services from the community program.

F. The QEs available include but are not limited to the following:

1. Children’s Programs - Molina Healthcare provides regular general wellness programs targeted specifically toward enrollees from birth to the age of five (5), or an alternative of making a good faith effort to involve the Member in an existing community Children’s Program.

   • Children’s programs shall promote increased use of prevention and early intervention services for at-risk enrollees. Molina Healthcare, Inc. shall approve claims for the services that are recommended by early intervention Programs when they are covered services and Medically Necessary. Molina Healthcare shall make a good faith effort to enter into and maintain agreements with the Local Early Intervention Program Office to establish methods of communication and procedures for the timely approval of services covered by Medicaid in accordance with s. 391.308, F.S.
• Molina Healthcare, Inc. offers annual training to providers that promote proper nutrition, breast-feeding, immunizations, Well Child visits, wellness, prevention and early intervention services.

2. Domestic Violence - Molina Healthcare ensures that Primary Care Providers (PCP) screen Members for signs of domestic violence and shall offer referral services to applicable domestic violence prevention community agencies.

3. Pregnancy Prevention - Molina Healthcare conducts regularly scheduled Pregnancy Prevention Programs or an alternative of making a good faith effort to involve Members in existing community pregnancy prevention programs. The programs are targeted towards teen Members but are open to all Members regardless of age, gender, pregnancy status or parental consent.

4. Prenatal/Postpartum Pregnancy Programs - Molina Healthcare provides regular home visits, conducted by a home health nurse or aide, and counseling with educational materials to pregnant and postpartum Members who are not in compliance with the Plan prenatal and postpartum programs. Molina Healthcare shall coordinate its effort with local Healthy Start Care Coordinator to prevent duplication of services.

5. Behavioral Health Programs – Molina Healthcare shall provide outreach to homeless and other populations of enrollees at risk of justice system involvement, as well as those enrollees currently involved in this system, to assure that services are accessible and provided when necessary. This activity shall be oriented toward preventive measures to assess behavioral health needs and provide services that can potentially prevent the need for future inpatient services or possible deeper involvement in the forensic or justice system.

6. Smoking Cessation - Molina Healthcare shall conduct regularly scheduled smoking cessation programs as an option for all enrollees. Molina Healthcare, Inc. shall make a good faith effort to involve enrollees in existing community or Smoking Cessation programs. Molina Healthcare, Inc. shall provide participating PCPs with the Quick Reference Guide[1] to assist in identifying tobacco users and supporting and delivering effective Smoking Cessation interventions. (Molina Healthcare, Inc. shall obtain copies of the guide by contacting the DHHS, Agency for Health Care Research & Quality (AHR) Publications Clearinghouse at (800) 358-9295 or P.O. Box 8547, Silver Spring, MD 20907).

7. Substance Abuse - Molina Healthcare offers annual Substance Abuse screening training to its contracted Providers.

• PCPs are required to screen Members for signs of Substance Abuse as part of prevention evaluation at the following times:
  o Initial contact with a new enrollee;
Managed Medical Assistance: Claims

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

What this means to Providers:
- Acute IPPS Hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing; 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 X12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 51062. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member’s Molina ID card.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

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.

**Electronic Claims Submission**
Molina requires 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 51062

**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.

Coordination of Benefits and Third Party Liability

COB
Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOBs and other required documents, by utilizing Molina’s Provider Portal.

Third Party Liability
Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.
**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 six (6) months after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within ninety (90) 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 State and 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). In the event a State benefit limit is more stringent/restrictive standard than a Federal MUE, Molina will apply the State benefit limit. Furthermore, if a profession organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit, the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCDs)
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCDs).
  - CMS Physician Fee Schedule Relative Value File (RVU) indicators.
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Molina policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Molina.

**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 and must include the original claim number in the resubmission field for claims submitted manually or electronically.
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 six (6) months 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 molinahealthcare.com or by contacting our Provider Services Department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, 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 one (1) year 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 Provider Dispute/Appeal Form 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, secure email or mail. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address:

**Molina Healthcare of Florida, Inc.**
**Attention: Grievance & Appeals Department**
**PO Box 527450**
**Miami, FL 33152-7450**

Submitted via fax:
(877) 553-6504

Secure email:
MFL_ProviderAppeals@MolinaHealthcare.com

**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 sixty (60) 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 no later than seven (7) days following the date on which the Molina adjudicates the claims 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
Managed Medical Assistance: Hospitals

This section includes policies and procedures specific to contracted hospitals. We have included information pertaining to Emergency Care, Admissions, Newborn Reporting Requirements and Claims.

Emergency Services

Emergency services are covered twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (365) days a year, for all Members experiencing an emergency medical situation.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of the Member, including a pregnant woman or fetus
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- A pregnant woman with contractions or rupture of membrane

Molina Healthcare shall not:

- Require prior authorization for a Member to receive pre-hospital transport or treatment or for emergency services and care;
- Specify or imply that emergency services and care are covered by Molina Healthcare only if secured within a certain period of time;
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
- Deny payment based on a failure by the enrollee or the hospital to notify Molina Healthcare before, or within a certain period of time after, emergency services and care were given.

Molina Healthcare shall cover pre-hospital and hospital-based trauma services and emergency services and care to Members.

When a Member presents at a hospital seeking emergency services and care, the determination that an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a hospital physician.

- The physician, or the appropriate personnel, shall indicate on the Member’s chart the results of all screenings, examinations and evaluations
• Molina Healthcare shall cover all screenings, evaluations and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the Member's condition is an emergency medical condition.

• If the provider determines that an emergency medical condition does not exist, the Managed Care Plan is not required to cover services rendered subsequent to the provider's determination unless authorized by the Managed Care Plan.

If the provider determines that an emergency medical condition exists, and the Member notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is a Member of Molina Healthcare, the hospital must make a reasonable attempt to notify:

• The Member's PCP, if known;
• Molina Healthcare, if the Health Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, does not know the Member's PCP, or has been unable to contact the PCP, the hospital must:

• Notify the Health Plan as soon as possible before discharging the Member from the emergency care area,
• Notify Molina Healthcare within twenty-four (24) hours or on the next business day after the Member's inpatient admission.

If the hospital is unable to notify Molina Healthcare, the hospital must document its attempts to notify Molina Healthcare, or the circumstances that precluded the hospital's attempts to notify the Plan. Molina Healthcare shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.

Molina Healthcare shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as Molina Healthcare can safely transport the enrollee to a participating facility. Molina Healthcare may transfer the Member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the Member's emergency medical condition. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.
Post-Stabilization Care Services

Molina Healthcare shall cover post- post-stabilization care services without authorization, regardless of whether the Member obtains a service within or outside the Plan’s network for the following situations:

- Post-stabilization care services that were pre-approved by the Health Plan
- Post-stabilization care services that were not pre-approved by the Health Plan because the Health Plan did not respond to the treating provider's request for pre-approval within one (1) hour after the treating provider sent the request.
- The treating provider could not contact the Health Plan for pre-approval.
- Those post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Health Plan can choose not to cover them if they are provided by a non-participating provider, except in those circumstances detailed above.

Admissions

Hospitals are required to notify Molina Healthcare 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.

Notification of admission must include clinical information needed to determine the appropriateness of the admission.

Newborn Reporting Requirements

Molina Healthcare must ensure that it notifies the Department of Children and Families (DCF) upon notification from the Hospital that a pregnant member has presented to the hospital for delivery.

Hospitals are required to notify Molina Healthcare when a pregnant Member presents to the hospital for delivery and provide information to Molina Healthcare that may be required for Molina Healthcare to complete the state’s Newborn Activation Form DCF-ES 2039. This form is located at http://www.fdhc.state.fl.us/Medicaid/Newborn.

Claims Submission

Claims must be submitted to Molina Healthcare with appropriate documentation electronically for CMS-1500 claims and UB-04 claims. Electronic claims may be submitted via EDI through a Clearinghouse, or through the Molina Provider Portal.

Providers billing Molina Healthcare electronically should use EDI Payor ID number - 51062
Molina Healthcare will only process claims containing the essential data requirements. If claim information is inaccurate or incomplete, a request will be issued on the provider’s RA for additional information.

Providers shall promptly submit to Molina Healthcare, claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Molina Healthcare, and shall include any and all medical records pertaining to the claim if requested by Molina Healthcare or otherwise required by Molina Healthcare’s policies and procedures. Provider can send claims with attachments by utilizing the Provider Portal. Claims must be submitted by Provider to Molina Healthcare within six (6) months after the following have occurred: discharge for inpatient services or the date of service for outpatient services; and Provider has been furnished with the correct name and address of the Member’s health plan. If Molina Healthcare is not the primary payer under coordination of benefits, Provider must submit claims to Health Plan within ninety (90) days after final determination by the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Health Plan within these timelines shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

Claim Editing Process

Molina Healthcare has a claims pre-payment auditing process that identifies frequent billing errors such as:

- Bundling and unbundling coding errors
- Duplicate claims
- Services included in global care
- Incorrect coding of services rendered


Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of coverage decisions or payment levels, Molina Healthcare determines that it has made an overpayment to a provider for services rendered to a Member, it will make a claim for such overpayment. Molina Healthcare will not reduce payment to that provider for other services unless the provider agrees to the reduction or fails to respond to Molina Healthcare’s claim as required in this subsection.

A provider shall pay a claim for an overpayment made by a Molina Healthcare which the provider does not contest or deny within sixty (60) days after the date on which the overpayment was identified.

A provider that denies or contests an organization’s claim for overpayment or any portion of a claim shall notify the organization, in writing, within (35) days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and,
if contested, must include a request for additional information. If the organization submits additional information, the organization must, within (35) days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within (45) days after receipt of the information.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to the organization, or the date that the provider receives a payment from the organization that reduces or deducts the overpayment. An overdue payment of a claim bears simple interest at the rate of (10) percent a year. Interest on an overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment has been received.

A provider shall pay or deny any claim for overpayment no later than (120) days after receiving the claim. Failure to do so creates an uncontestable obligation for the provider to pay the claim to the organization.

Billing the Member

Molina Healthcare contracted providers may not bill the Member for any covered benefit. The contract between the provider and Molina Healthcare places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization on the provider. Additionally, Molina waives copayments as an expanded benefit to its members. Contracted providers must not require a copayment for covered services.

Managed Medical Assistance: HIPAA

HIPAA - The Health Insurance Portability and Accountability Act

Molina Healthcare’s Commitment to Patient Privacy

Protecting the privacy of members’ personal health information is a core responsibility that Molina Healthcare takes very seriously. Molina Healthcare is committed to complying with all federal and state laws regarding the privacy and security of members’ Protected Health Information (PHI).

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted Providers/Practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Providers must 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. Providers must ensure their staff receives periodic training regarding the confidentiality of Member information.
Applicable Laws

Providers/Practitioners must understand all state and federal healthcare 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/Practitioners must comply with. In general, most healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
   - HIPAA
   - Medicare and Medicaid laws

2. Applicable State of Florida Laws and Regulations

Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/Practitioners 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/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare 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/Practitioner’s own TPO activities, but also for the TPO of another covered entity. Disclosure of PHI by one covered entity to another covered entity, or healthcare 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 healthcare provider for the payment activities of the recipient. Please note that “payment” is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of “services.”

2. 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;

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

2 See, Section 164.504(a) of the HIPAA Privacy Rule.
Accreditation, licensing, and credentialing

Importantly, this allows Providers/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

Written Authorizations

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

Patient Rights

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

1. **Notice of Privacy Practices**

 Providers/Practitioners 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/Practitioner 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 healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

 Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners 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/Practitioner’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/Practitioner 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/Practitioner 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/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.

HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare 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 healthcare 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 Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare requires the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers/Practitioners must submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions 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 Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners should refer to Molina Healthcare’s website at: http://www.molinahealthcare.com for additional information on HIPAA standard transactions.

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

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to Molina Healthcare’s website at: [http://www.molinahealthcare.com](http://www.molinahealthcare.com) for additional information.

**National Provider Identifier**

Provider/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider/Practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider/Practitioner. The Provider/Practitioner must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Provider/Practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to Molina Healthcare.

**Additional Requirements for Delegated Providers/Practitioners**

Providers/Practitioners that are delegated for claims and utilization management activities are the “business associates” of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers/Practitioners must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.
Managed Medical Assistance: Fraud, Waste, & Abuse

Introduction

Molina Healthcare of Florida maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. Molina Healthcare of Florida is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare of Florida will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina’s Special Investigation Unit supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of Florida.

Mission Statement

Molina Healthcare of Florida 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 Healthcare of Florida 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, including the Medicare and Medicaid programs. 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.

Florida False Claims Act
Florida has also enacted a state False Claims Act (F.S. Title VI, §§ 68.081-68.089) in 2007 to allow for the recovery of state funds in addition to federal funds for false claims. The provisions of the Florida False Claims Act (FFCA) are similar, but not identical to, the provisions of the federal FCA. The FFCA provides for civil penalties of not less than $5,500 and not more than $11,000 per violation, for three times the damages to state government due to false claims, and for recovery of attorney's fees and court costs.

**Deficit Reduction Act**

On February 8, 2006, the Deficit Reduction Act (“DRA”) was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Florida who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare of Florida, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers.

**Whistleblower Protection**

The Federal False Claims Act, the Florida False Claims Act, and the Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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

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

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

**Fraud:**

“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. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

**Abuse:**

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid 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 Medicaid programs. (42 CFR § 455.2)

**Examples of Fraud, Waste and Abuse by a Provider**

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider’s usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, “unbundling” of procedures, non-covered treatments to receive payment, “up-coding”, and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of Florida identification card.
• Failure to report a patient’s forgery/alteration of a prescription.

• Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.

• A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)

**Review of Provider**

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

• Federal and State Medicaid sanction reports.
• Federal and state lists of excluded individuals and entities including the Florida Agency for Healthcare Administration’s list of suspended and terminated providers at: [http://apps.ahca.myflorida.com/dm_web](http://apps.ahca.myflorida.com/dm_web)
• List of parties excluded from Federal Procurement and Non-procurement Programs.
• Medicaid suspended and ineligible provider list.
• Monthly review of state Medical Board sanctions list.
• Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

**Provider Profiling**

Molina Healthcare of Florida performs claims audits to detect potential external health care fraud, waste, or abuse. These audits of provider billings are based on objective and documented criteria. Molina Healthcare of Florida uses a fraud, waste, and abuse detection software application designed to score and profile provider and member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or member’s prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. If a score reaches a certain parameter or threshold, the provider or member is placed on a list for further review.
Molina Healthcare of Florida will inform the provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

**Provider/Practitioner Education**

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

The Molina Healthcare of Florida Provider Services Representative will inform the provider's office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

**Review of Provider Claims and Claims System**

Molina Healthcare 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 preformed as authorized.

Molina Healthcare of Florida 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.

**Cooperating with Special Investigation Unit Activities**

Molina Healthcare’s Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities, and will provide requested documentation to the unit following the timelines indicated in such requests. Failure to cooperate may result in further action, up to and including termination of the Provider contract.

**Reporting Fraud, Waste and Abuse**

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare 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 Healthcare AlertLine can be reached toll free at 1-866-606-3889 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 Healthcare of Florida’s Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Florida
Attn: Compliance Department
8300 NW 33rd St, Suite 400
Doral, FL 33122

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, Medicaid ID number and any other identifying information.

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/

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

Department of Financial Services
Division of Insurance Fraud
200 East Gaines Street
Tallahassee, FL 32399-0318
Toll Free Phone: (877) 693-5236

Florida Attorney General
Fraud Hotline: (866) 966-7226

If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General’s Fraud Rewards Program (toll-free (866) 966-7226 or (850) 414-3990). The reward may be up to twenty- five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General’s Office about keeping your identity confidential and protected.
Managed Medical Assistance: Credentialing

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. Urgent care services are medically necessary services, which are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. 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.

**Criteria for Participation in the Molina Network**

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of 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. These criteria and the sources used to verify these criteria are listed in the table below.

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 Credentialing 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.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>VERIFICATION SOURCE</th>
<th>APPLICABLE PROVIDER TYPE</th>
<th>TIME LIMIT WHEN REQUIRED</th>
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<tbody>
<tr>
<td>Application Provider must submit to Molina a complete, signed and dated credentialing application. The application must be typewritten or completed in non-erasable ink. Application must include all required attachments.</td>
<td>▪ Every section of the application is complete or designated N/A ▪ Every question is answered ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision ▪ All required</td>
<td>All Provider types</td>
<td>One-hundred-eighty (180) Calendar Days</td>
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<td>Initial &amp; Recredentialing</td>
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<tr>
<td>The Provider must sign and date the application attesting their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. <strong>If the Provider's attestation exceeds one-hundred-eighty (180) days before the credentialing decision, the Provider must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the Provider to update the attestation.</strong></td>
<td>attachments are present • Every professional question is clearly answered and the page is completely legible • A detailed written response is included for every yes answer on the professional questions</td>
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<tr>
<td>If Molina or the Credentialing Committee requests any additional information or clarification, the Provider must supply that information in the period requested.</td>
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<tr>
<td>Any changes made to the application must be initialed and dated by the Provider. Whiteout may not be used on the application rather the incorrect information must have a line drawn through it with the correct information written/typed and must be initialed and dated by the Provider.</td>
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<tr>
<td>If a copy of an application from an entity external to Molina is used, it must</td>
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include an attestation to the correctness and completeness of the application. Molina does not consider the associated attestation elements as present if the Provider did not attest to the application within the required period of one-hundred-eighty (180) days. If State regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation.

The application and/or attestation documents cannot be altered or modified.

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<tr>
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<th>APPLICABLE PROVIDER TYPE</th>
<th>TIME LIMIT WHEN REQUIRED</th>
</tr>
</thead>
</table>
| License, Certification or Registration | Verified directly with the appropriate State licensing or certification agency. This verification is conducted by one of the following methods:  
- On-line directly with licensing board  
- Confirmation directly from the appropriate State agency.  
The verification must indicate:  
- The scope/type of license  
- The date of original licensure  
- Expiration date  
- Status of license  
- If there have been, or currently are, any disciplinary action or sanctions on the license. | All Provider types who are required to hold a license, certification or registration to practice in their State | Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days |

Initial & Recredentialing
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<tr>
<th>CRITERIA</th>
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<th>TIME LIMIT</th>
<th>WHEN REQUIRED</th>
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<tr>
<td>Provider’s acts, omissions or conduct, Molina will verify all licenses, certifications and registrations in every State where the Provider has practiced.</td>
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| **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.  
If a Provider has a pending DEA/CDS certificate because of just starting practice or because of moving to a new State, the Provider may be credentialed on “watch” status provided that Molina has a written prescription plan from the Provider. This plan must describe the process for allowing another Provider with a valid DEA/CDS certificate to write all prescriptions requiring a DEA/CDS number.  
If a Provider has never had any disciplinary action taken related to his/her DEA or CDS and chooses not to have a DEA or CDS certificate, the Provider may be considered for network participation if they submit a prescription plan for another Provider with a valid DEA or CDS certificate to write all prescriptions. | DEA or CDS is verified by one of the following:  
- On-line directly with the National Technical Information Service (NTIS) database.  
- On-line directly with the U.S. Department of Justice Drug Enforcement Administration, Office of Diversion Control  
- Current, legible copy of DEA or CDS certificate  
- On-line directly with the State pharmaceutical licensing agency, where applicable | Physicians, Oral Surgeons, Nurse Providers, Physician Assistants, Podiatrists | Must be in effect at the time of decision and verified within one-hundred-eighty (180) Calendar Days | Initial & Recredentialing |

Written prescription plans:  
- A written prescription plan must be received from the Provider. It must indicate another Provider with a valid DEA or CDS certificate to write all prescriptions requiring a DEA number.  
- Molina must primary source verify the covering Providers DEA. |
If a Provider does not have a DEA because it has been revoked, restricted or relinquished due to disciplinary reasons, the Provider is not eligible to participate in the Molina network.

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<tr>
<th>CRITERIA</th>
<th>VERIFICATION SOURCE</th>
<th>APPLICABLE PROVIDER TYPE</th>
<th>TIME LIMIT WHEN REQUIRED</th>
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<tbody>
<tr>
<td><strong>Education &amp; Training</strong></td>
<td>Providers will only be credentialed in an area of practice in which they have adequate education and training as outlined below. Therefore, Providers must confine their practice to their credentialed area of practice when providing services to Molina Members.</td>
<td>Education, Residency, Fellowship and Board Certification.</td>
<td>All Provider Types</td>
</tr>
</tbody>
</table>
| **Education**             | Provider must have graduated from an accredited school with a degree required to practice in their specialty. | The highest level of education is primary source verified by one of the following methods:  
  - Primary source verification of Board Certification as outlined in the Board Certification section of this policy.  
  - Confirmation from the State licensing agency when Molina has documentation that the State agency conducts primary source verification of the highest level of education and this confirmation is not greater than 12-months old.  
  - The American Medical Association (AMA) Physician Master File. This verification must indicate the | All Provider types | Prior to credentialing decision | Initial Credentialing |
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<td>education has specifically been verified.</td>
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<td>• The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the education has specifically been verified.</td>
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<td>• Confirmation directly from the accredited school. This verification must include the type of education, the date started, date completed and if the Provider graduated from the program.</td>
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<td>• Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.</td>
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<td>• Association of schools of the health professionals, if the association performs primary-source verification of graduation from medical school and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old.</td>
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<td>• If a physician has</td>
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<td>completed education and training through the AMA's Fifth Pathway program, this must be verified through the AMA. <strong>•</strong> Confirmation directly from the National Student Clearing House. This verification must include the name of the accredited school, type of education and dates of attendance.</td>
<td>Oral Surgeons, Physicians, Podiatrists</td>
<td>Prior to credentialing decision</td>
<td>Initial Credentialing</td>
</tr>
<tr>
<td>Residency Training</td>
<td>Provider must have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Verification of the residency is always required except for General Providers as described in the General Provider section below. Molina only recognizes residency programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the</td>
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<td>Residency Training is primary source verified by one of the following methods: <strong>•</strong> Primary source verification of current or expired board certification in the same specialty of the Residency Training program (as outlined in the Board Certification section of this policy). <strong>•</strong> The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified. <strong>•</strong> The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified.</td>
<td>Oral Surgeons, Physicians, Podiatrists</td>
<td>Prior to credentialing decision</td>
<td>Initial Credentialing</td>
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</table>
Commission on Dental Accreditation (CODA).

Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program.

- Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed.
- Association of schools of the health professionals, if the association performs primary-source verification of residency training and Molina has written confirmation from the association that it performs primary source verification of graduation and this confirmation is not greater than twelve (12) months old.
- For Closed Residency Programs, residency completion can be verified through the Federation of State Medical Boards Federation Credentials Verification Service (FCVS).
- For podiatrists, confirmation directly from the Council of Podiatric Medical Education (CPME) verifying podiatry residency program. This verification must include the type of training program,
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<td></td>
<td>specialty of training, the date started, date completed and if the program was successfully completed.</td>
<td>Physicians</td>
<td>Prior to credentialing decision</td>
<td>Initial Credentialing</td>
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</tbody>
</table>
| Fellowship Training | Fellowship Training is primary source verified by one of the following methods:  
- Primary source verification of current or expired Board Certification in the same specialty of the Fellowship Training program (as outlined in the Board Certification section of this policy).  
- The American Medical Association (AMA) Physician Master File. This verification must indicate the training has specifically been verified.  
- The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File. This verification must indicate the training has specifically been verified.  
- Confirmation directly from the accredited training program. This verification must include the type of training program, specialty of training, the date started, date completed and if the program was successfully completed. | Physicians | Prior to credentialing decision | Initial Credentialing |
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<th>CRITERIA</th>
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</table>
| Board Certification | Board certification is primary source verified through one of the following:  
- An official ABMS (American Board of Medical Specialties) display agent, where a dated certificate of primary-source authenticity has been provided (as applicable).  
- AMA Physician Master File profile (as applicable).  
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File (as applicable).  
- Confirmation directly from the board. This verification must include the specialty of the certification(s), the original certification date, and the expiration date.  
- On-line directly from the American Board of Podiatric Surgery (ABPS) verification website (as applicable).  
- On-line directly from the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM) website (as applicable).  
- On-line directly from the American Board of Oral and Maxillofacial Surgery website | Dentists, Oral Surgeons, Physicians, Podiatrists | Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days | Initial & Recredentialing |

Molina recognizes board certification only from the following Boards:  
- American Board of Medical Specialties (ABMS)  
- American Osteopathic Association (AOA)  
- American Board of Foot and Ankle Surgery (ABFAS)  
- American Board of Podiatric Medicine (ABPM)  
- American Board of Oral and Maxillofacial Surgery  
- American Board of Addiction Medicine (ABAM)  

Molina must document the expiration date of the board certification within the credentialing file. If the board certification does not expire, Molina must verify a lifetime certification status and document in the credentialing file.  

American Board of Medical Specialties Maintenance of Board Certification
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</table>
| Certification Programs (MOC) – Board certified Providers that fall under the certification standards specified that board certification is contingent upon meeting the ongoing requirements of MOC, no longer list specific end dates to board certification. Molina will list the certification as active without an expiration date and add the document in the credentialing file. | [www.aboms.org](http://www.aboms.org) (as applicable).  
- On-line directly from the American Board of Addiction Medicine website [https://www.abam.net/find-a-doctor](https://www.abam.net/find-a-doctor) (as applicable). | Physicians | One-hundred-eighty (180) Calendar Days | Initial Credentialing |
| General Practitioner Providers who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general Provider in the Molina network. To be eligible, the Provider must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Molina will consider allowing a Provider who is/was board certified and/or residency trained to participate as a general Provider, if the Provider is applying to participate in one of the following specialties:  
- Primary Care Physician  
- Urgent Care  
- Wound Care | The last five years of work history in a PCP/General practice must be included on the application or curriculum vitae and must include the beginning and ending month and year for each work experience. Any gaps exceeding six months will be reviewed and clarified either verbally or in writing. Verbal communication will be appropriately documented in the credentialing file. A gap in work history that exceeds 1 year will be clarified in writing directly from the Provider. | Physicians | One-hundred-eighty (180) Calendar Days | Initial Credentialing |
<p>| Advanced Practice Nurse Providers | Board certification is verified through one of the following: | Nurse Providers | One-hundred-eighty (180) | Initial and Recredentialing |</p>
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</table>
| Advanced Practice Nurse Providers must be board certified or eligible to become board certified in the specialty in which they are requesting to practice. Molina recognizes Board Certification only from the following Boards:  
- American Nurses Credentialing Center (ANCC)  
- American Academy of Nurse Providers Certification Program (AANP)  
- Pediatric Nursing Certification Board (PNCB)  
- National Certification Corporation (NCC) | Confirmation directly from the board. This verification must include the specialty/scope of the certification(s), the original certification date, and the expiration date.  
- Current copy of the board certification certificate including the specialty/scope of the certifications(s), the original certification date and the expiration date  
- On-line directly with licensing board, if the licensing primary verifies a Molina recognized board certification. License must indicate board certification/scope of practice.  
- Provider attests on their application to board certification including the specialty/scope of the certifications(s), the original certification date and the expiration date. | Calendar Days | | |
| Physician Assistants  
Physician Assistants must be licensed as a Certified Physician Assistant.  
Physician Assistants must also be currently board certified or eligible to become board certified the National Commission on Certification of Physician Assistants (NCPA). | Board certification is primary source verified through the following:  
- On-line directly from the National Commission on Certification of Physician Assistants (NCPA) website [https://www.nccpa.net/](https://www.nccpa.net/). | Physician Assistants | One-hundred-eighty (180) Calendar Days | Initial and Recredentialing |
<p>| Providers Not Able To Practice Independently | Confirm from Molina’s systems that Nurse Providers, Must be in effect at the | | Initial &amp; Recredentialing |</p>
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<tr>
<td>In certain circumstances, Molina may credential a Provider who is not licensed to practice independently. In these instances it would also be required that the Provider providing the supervision and/or oversight be contracted and credentialed with Molina. Some examples of these types of Providers include: • Physician Assistants • Nurse Providers</td>
<td>the Provider providing supervision and/or oversight has been credentialed and contracted.</td>
<td>Physician Assistants and other Providers not able to practice independently according to State law</td>
<td>time of decision and verified within One-hundred-eighty (180) Calendar Days</td>
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<tr>
<td><strong>Work History</strong></td>
<td>Provider must supply a minimum of 5-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If the Provider has practiced fewer than 5-years from the date of Credentialing, the work history starts at the time of initial licensure. Experience practicing as a non-physician health professional (e.g. registered nurse, nurse Provider, clinical social worker) within the 5 years should be included. If Molina determines there is a gap in work history exceeding six-months, the Provider must clarify the gap either verbally or in writing. Verbal communication must be appropriately documented in the credentialing file. If Molina determines there is a gap in work history that exceeds one-year, the</td>
<td>The credentialing application or curriculum vitae must include at least 5-years of work history and must include the beginning and ending month and year for each position in the Provider's employment experience. If a Provider has had continuous employment for five years or more, then there is no gap and no need to provide the month and year; providing the year meets the intent. Molina documents review of work history by including an electronic signature or initials of the employee who reviewed the work history and the date of review on the credentialing checklist or on any of the work history documentation.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
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<tr>
<td>Provider must clarify the gap in writing.</td>
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<tr>
<td><strong>Malpractice History</strong></td>
<td>National Provider Data Bank (NPDB) report</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<tr>
<td>Provider must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the Provider on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</td>
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<tr>
<td><strong>State Sanctions, Restrictions on licensure or limitations on scope of practice</strong></td>
<td>Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. The appropriate State/Federal agencies are queried directly for every Provider and if there are any sanctions, restrictions or limitations, complete documentation regarding the action will be requested. The NPDB is queried for every Provider.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<td>CRITERIA</td>
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<td>the application, a detailed response is required from the Provider. Molina will also verify all licenses, certifications and registrations in every State where the Provider has practiced.</td>
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<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<td>At the time of initial application, the Provider must not have any pending or open investigations from any State or governmental professional disciplinary body.¹. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.</td>
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<td>Medicare, Medicaid and other Sanctions</td>
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<td>Provider must not be currently sanctioned, excluded, expelled or suspended from any State or federally funded program including but not limited to the Medicare or Medicaid programs.</td>
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<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<td>Provider must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.</td>
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<td>Provider must disclose all debarments, suspensions, proposals for debarments,</td>
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<td>• The HHS Inspector General, Office of Inspector General (OIG) is queried for every Provider.</td>
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<td>• Molina queries for State Medicaid sanctions/exclusions/ terminations through each State’s specific Program Integrity Unit (or equivalent). In certain circumstances where the State does not provide means to verify this information and Molina has no way to verify State Medicaid sanctions/exclusions/ terminations.</td>
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<td>• The System for Award Management</td>
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¹ If a Provider’s application is denied solely because a Provider has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the Provider may reapply as soon as Provider is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one (1) year from the date of original denial.
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| exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. | (SAM) system is queried for every Provider.  
• The NPDB is queried for every Provider. | | | |
| **Professional Liability Insurance**  
Provider must have and maintain professional malpractice liability insurance with limits that meet Molina criteria as stated below unless otherwise stated in addendum B. This coverage shall extend to Molina Members and the Providers activities on Molina’s behalf. | A copy of the insurance certificate showing:  
• Name of commercial carrier or statutory authority  
• The type of coverage is professional liability or medical malpractice insurance  
• Dates of coverage (must be currently in effect)  
• Amounts of coverage  
• Either the specific Provider name or the name of the group in which the Provider works  
• Certificate must be legible | All Provider types | Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days | Initial & Recredentialing |
<p>| <strong>All Provider types</strong> | | | | |</p>
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| **Therapy, Physical Therapy, Speech Language Pathology = $200,000/$600,000** | - malpractice insurance  
  - Dates of coverage (must be currently in effect)  
  - Amounts of coverage  
  Providers maintaining coverage under a Federal tort or self-insured are not required to include amounts of coverage on their application for professional or medical malpractice insurance. A copy of the Federal tort or self-insured letter or an attestation from the Provider showing active coverage are acceptable.  
  Confirmation directly from the insurance carrier verifying the following:  
  - Name of commercial carrier or statutory authority  
  - The type of coverage is professional liability or medical malpractice insurance  
  - Dates of coverage (must be currently in effect)  
  - Amounts of coverage | All Providers | One-hundred-eighty (180) Calendar Days | Initial & Recredentialing |
| **Inability to Perform**  
 Provider must disclose any inability to perform essential functions of a Provider in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the | Provider must answer all the related questions on the credentialing application.  
 If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. | All Providers | | |
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<tr>
<td>application, a detailed response is required from the Provider. An inquiry regarding inability to perform essential functions may vary. Molina may accept more general or extensive language to query Providers about impairments.</td>
<td>▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<tr>
<td>Lack of Present Illegal Drug Use Provider must disclose if they are currently using any illegal drugs/substances. An inquiry regarding illegal drug use may vary. Providers may use language other than &quot;drug&quot; to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query Providers about impairments; language does not have to refer exclusively to the present, or only to illegal substances. If a Provider discloses any issues with substance abuse (e.g. drugs, alcohol) the Provider must provide evidence of either actively and successfully participating in a substance abuse monitoring program or successfully completing a program. The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision</td>
<td>▪ Provider must answer all the related questions on the credentialing application. ▪ If there are any yes answers to these questions, a detailed written response must be submitted by the Provider. ▪ If the Provider discloses they are currently participating in a substance abuse monitoring program, Molina will verify directly with the applicable substance abuse monitoring program to ensure the Provider is compliant in the program or has successfully completed the program.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<tr>
<td>Criminal Convictions Provider must disclose if they have ever had any criminal convictions. If</td>
<td>▪ Provider must answer the related questions on the credentialing</td>
<td>All Providers</td>
<td>One-hundred-eighty (180)</td>
<td>Initial &amp; Recredentialing</td>
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<td>there is an affirmative response to the related disclosure questions on</td>
<td>application. If there are any yes answers to these questions, a detailed written</td>
<td>All Providers</td>
<td>Calendar Days</td>
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<td>the application, a detailed response is required from the Provider.</td>
<td>response must be submitted by the Provider.</td>
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<td>Provider must not have been convicted of a felony or pled guilty to a</td>
<td>- If there are any yes answers to these questions, and the crime is related to health</td>
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<td>felony for a healthcare related crime including but not limited to</td>
<td>care, a national criminal history check will be run on the Provider.</td>
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<td>healthcare fraud, patient abuse and the unlawful manufacture distribution</td>
<td>- The attestation must be signed and dated within one-hundred-eighty (180) calendar</td>
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<td>or dispensing of a controlled substance.</td>
<td>days of credentialing decision</td>
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**Loss or Limitation of Clinical Privileges**
Provider must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Provider has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.

- Provider must answer the related questions on the credentialing application. If there are any yes answers to these questions, a detailed written response must be submitted by the Provider.
  - The NPDB will be queried for all Providers.
  - If the Provider has had disciplinary action related to clinical privileges in the last five (5) years, all hospitals where the Provider has ever had privileges will be queried for any information regarding the loss or limitation of their privileges.
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<tr>
<th>CRITERIA</th>
<th>VERIFICATION SOURCE</th>
<th>APPLICABLE PROVIDER TYPE</th>
<th>TIME LIMIT</th>
<th>WHEN REQUIRED</th>
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<tbody>
<tr>
<td><strong>Hospital Privileges</strong></td>
<td>The Provider’s hospital privileges are verified by their attestation on the credentialing application stating the Provider has current hospital admitting privileges.</td>
<td>Physicians and Podiatrists</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<td>Provider must list all current hospital privileges on their credentialing application. If the Provider has current privileges, they must be in good standing.</td>
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<td></td>
<td>Providers may choose not to have clinical hospital privileges if they do not manage care in the inpatient setting.</td>
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<tr>
<td><strong>Medicare Opt Out</strong></td>
<td>CMS Medicare Opt Out is queried for every Provider. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years and may not be contracted with Molina for any Medicare or Duals (Medicare/Medicaid) lines of business.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<td>Providers currently listed on the Medicare Opt-Out Report may not participate in the Molina network for any Medicare or Duals (Medicare/Medicaid) lines of business.</td>
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<tr>
<td><strong>NPI</strong></td>
<td>On-line directly with the National Plan &amp; Provider Enumeration System (NPPES) database.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<tr>
<td>Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).</td>
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<tr>
<td><strong>SSA Death Master File</strong></td>
<td>On-line directly with the Social Security Administration Death Master File database.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial &amp; Recredentialing</td>
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<td>Providers must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.</td>
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<td>If a Provider’s Social Security number is listed on the SSA Death Master File database, Molina will send the Provider a conflicting information letter to confirm the Social Security number listed on</td>
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<td>CRITERIA</td>
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<td>the credentialing application was correct.</td>
<td>If the Provider confirms the Social Security number listed on the SSA Death Master database is their number, the Provider will be administratively denied or terminated. Once the Provider’s Social Security number has been removed from the SSA Death Master File database, the Provider can reapply for participation into the Molina network.</td>
<td>Written documentation from the Molina Quality Department and other departments as applicable will be included in all recredentialing files.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
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<tr>
<td>Review of Performance Indicators</td>
<td>Providers going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators.</td>
<td>Confirmation from Molina’s systems that the Provider has not been denied by the Molina Credentialing Committee in the past 1-year.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
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<tr>
<td>Denials</td>
<td>Providers denied by the Molina Credentialing Committee are not eligible to reapply until one (1) year after the date of denial by the Credentialing Committee. At the time of reapplication, Provider must meet all criteria for participation.</td>
<td>Confirmation from Molina’s systems that the Provider has not been denied by the Molina Credentialing Committee in the past 1-year.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
</tr>
<tr>
<td>Terminations</td>
<td>Providers terminated by the Molina Credentialing Committee or terminated from the Molina network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, Provider must meet all criteria for participation.</td>
<td>Confirmation from Molina’s systems that the Provider has not been terminated by the Molina Credentialing Committee or terminated from the Molina network.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
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<td>CRITERIA</td>
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<td>reapplication, Provider must meet all criteria for participation.</td>
<td>cause in the past 5-years.</td>
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<td>Administrative denials and terminations</td>
<td>• Confirmation from Molina’s systems if a Provider was denied or terminated from the Molina network, that the reason was administrative as described in this policy.</td>
<td>All Providers</td>
<td>One-hundred-eighty (180) Calendar Days</td>
<td>Initial Credentialing</td>
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<tr>
<td>Employees of Providers denied, terminated, under investigation or in the Fair Hearing Process</td>
<td>When a Provider is denied or terminated from network participation or who is under investigation by Molina, it will be verified if that Provider has any employees. That information will be reviewed by the Credentialing Committee and/or Medical Director and a determination will be made if they can continue participating in the network.</td>
<td>All Providers</td>
<td>Not applicable</td>
<td>Initial and Recredentialing</td>
</tr>
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Molina may determine, in its sole discretion, that a Provider is not eligible to apply for network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina.

Molina also may determine, in its sole discretion that a Provider cannot continue network participation if the Provider is an employee of a Provider or an employee of a company owned in whole or in part by a Provider, who has been denied or terminated from network participation by Molina. For purposes of these criteria, a company is “owned” by a Provider when the Provider has at
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<td>least five percent (5%) financial interest in the company, through shares or other means.</td>
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**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 Credentialing Committee’s review must be re-verified. The Credentialing 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 credential 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.

**Providers Terminating with a Delegate and Contracting with Molina Directly**

Providers credentialed by a delegate who terminate their contract with the delegate and either have an existing contract with Molina or wish to contract with Molina directly must be credentialed by Molina within six (6) months of the Provider’s termination with the delegate. If the Provider has a break in service more than thirty (30) calendar days, the Provider must be initially credentialed prior to reinstatement.
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. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina may use another organization's application as long as it meets all the factors. Molina will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. 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.

The Process for Making Credentialing Decisions

All Providers requesting participation with Molina must complete a credentialing application. To be eligible to submit an application, Providers must meet all the criteria outlined above in the section titled “Criteria for Participation in the Molina Network”. Providers requesting initial credentialing may not provide care to Molina Members until the credentialing process is complete and final decision has been rendered.

Molina recredentials its Providers at least every thirty-six (36) months. Approximately six (6) months prior to the recredentialing due date, the Provider’s application will be downloaded from CAQH (or a similar NCQA© accepted online applications source), or a request will be sent to the Provider requesting completion of a recredentialing application.

During the initial and recredentialing application process, the Provider must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last one-hundred-eighty (180) calendar days
- Provide Molina adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network.

Once the application is received, Molina will complete all the verifications as outlined in the Molina Credentialing Program Policy. In order for the application to be deemed complete, the Provider must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina must be provided.
If the Provider does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or administrative termination from the Molina network. Providers who fail to provide proof of meeting the criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process, each credentialing file is assigned a level based on the guidelines below. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Credentialing Committee. The Medical Director has the right to request the Credentialing Committee review any credentials file. The Credentialing Committee has the right to request to review any credentials file.

**Process for Delegating Credentialing and Recredentialing**

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina’s requirements for delegation. Molina’s Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina’s requirements.

Molina’s Credentialing Committee retains the right to approve new Providers and Provider sites and terminate Providers, Providers and sites of care based on requirements in the Molina Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA)© accredited or certified for credentialing or pass Molina’s credentialing delegation pre-assessment, which is based on NCQA© credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least ninety percent (90%).
- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment.
- Agree to Molina’s contract terms and conditions for credentialing delegates.
- Submit timely and complete reports to Molina as described in policy and procedure.
- Comply with all applicable Federal and State Laws.
- If the IPA or Provider Group sub-delegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA© certified in all ten areas of accreditation.

**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.
Prevention
Molina takes appropriate steps to protect against discrimination occurring in the credentialing and recredentialing processes. Molina maintains a heterogeneous credentialing committee Membership. It is also required that each committee Member signs an affirmative statement annually to make decisions in a nondiscriminatory manner.

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 Credentialing Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two 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.

Confidentiality and Immunity
Information regarding any Provider or Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under this Policy and Procedure. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a “Representative” shall mean any individual authorized to perform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section “information” may be any written or oral disclosures including, but not limited to, a Provider’s or Provider’s professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or Provider’s provision of patient care services.

By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the Provider’s qualifications.
2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal Claims against any representative who acts in accordance with the provisions of this policy and procedure.
3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina Membership and the continuation of such membership, and to the exercise of clinical privileges or provision of patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider;
2. Actions reducing, suspending, terminating or revoking a Provider’s status, including requests for corrective actions, investigation reports and documents and all other information related to such action;
3. Hearing and appellate review;
4. Peer review and utilization and quality management activities;
5. Risk management activities and Claims review;
6. Potential or actual liability exposure issues;
7. Incident and/or investigative reports;
8. Claims review;
9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;
10. Any activities related to monitoring the quality, appropriateness or safety of health care services;
11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;
12. Any Molina operations and actions relating to Provider conduct.

Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by; Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant State and Federal Law, and are not a limitation thereof.

All Members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by Law. Access to these documents are restricted to authorized staff, Credentialing Committee Members, peer reviewers and reporting bodies as authorized by the
Credentialing Committee or the Governing Board of Molina. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three (3) months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable Laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Staff is instructed not to divulge passwords to their co-workers.

**Providers Rights during the Credentialing Process**

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

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 Improvement 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. Providers applying for initial participation are sent a letter when their application is received by Molina and are notified of their right to be informed of the status of their application in this letter.

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.

**Credentialing Committee**

Molina designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina works with the Credentialing Committee to strive to assure that network Providers are competent and qualified to provide continuous quality care to Molina Members. A Provider may not provide care to Molina Members until the credentialing process is complete and the final decision has been rendered.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicants and for making recommendations regarding their participation in the Molina network. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network Providers, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).
Each Credentialing Committee Member shall be immune, to the fullest extent provided by Law, from liability to an applicant or Provider for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

Committee Composition

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee Members. Each Member is required to meet all of Molina's credentialing criteria. Credentialing Committee Members must be current representatives of Molina's Provider network. The Credentialing Committee representation includes at least five Providers. These may include Providers from the following specialties:

- Behavioral Health
- Dental
- Family Medicine
- Internal Medicine
- Pediatrics
- OB/GYN
- Surgery

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc Providers may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Nurses and Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

Committee Members Roles and Responsibilities

- Committee Members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.
- Review/approve credentialing program policy and related policies established by Molina on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements. The Credentialing Committee votes to make final recommendations regarding applicant's participation in the Molina network.
- Conduct ongoing monitoring of those Providers approved to be monitored on a “watch status”.
- Access clinical peer input when discussing standards of care for a particular type of Provider when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with Molina's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

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 Provider sanctions between recredentialing cycles for all Provider types and takes appropriate action against Providers when occurrences of poor quality is identified.

Medicare and Medicaid Sanctions and Exclusions
The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within thirty (30) calendar days of its release, Molina reviews the report to identify if any Molina Provider is found with a sanction. If a Molina Provider is found to be sanctioned by the OIG the Provider’s contract will immediately be terminated effective the same date the sanction was implemented.

Molina also monitors each State Medicaid sanctions/exclusions/terminations through each State’s specific Program Integrity Unit (or equivalent). Molina reviews each State’s published report within thirty (30) days of its release to identify if any Molina Provider is found to be sanctioned/excluded/terminated from any State’s Medicaid program,. If a Molina Provider is found to be sanctioned/excluded/terminated, the Provider will be immediately terminated in every State where they are contracted with Molina and for every line of business.

Sanctions or Limitations on Licensure
Molina monitors for sanctions or limitations against licensure between credentialing cycles for all network Providers. All sanction or limitation of license information discovered during the ongoing monitoring process will be maintained in the Provider credentialing file. All Providers with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a recommendation.

NPDB Continuous Query
Molina enrolls all network Providers with the National Practitioner Data Bank (“NPDB”) Continuous Query service.

Once the Provider is enrolled in the Continuous Query Service, Molina will receive instant notification of all new NPDB reports against the enrolled Providers. When a new report is received between recredentialing cycles, the Provider will be immediately placed into the full credentialing process and will be recredentialed early. The Provider must provide all necessary information to complete the recredentialing process within the requested time-frames or the Provider will be administratively terminated from the network. The complete recredentialing file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

**Member Complaints/Grievances**

Each Molina Health Plan has a process in place to investigate Provider-specific complaints from Members upon their receipt. Molina evaluates both the specific complaint and the Provider's history of issues, if applicable. The history of complaints is evaluated for all Providers at least every six (6) months.

**Adverse Events**

Each Molina Health Plan has a process in place for monitoring Provider adverse events at least every six (6) months. An adverse event is an injury that occurs while a Member is receiving health care services from a Provider. Molina monitors for adverse events at least every six (6) months.

**Medicare Opt-Out**

Providers participating in Medicare must not be listed on the Medicare Opt-Out report. Molina reviews the Opt-Out reports released from the appropriate Medicare financial intermediary showing all of the providers who have chosen to Opt-Out of Medicare. These reports are reviewed within thirty (30) calendar days of their release. If a Provider opts out of Medicare, that Provider may not accept Federal reimbursement for a period of two (2) years. These Provider contracts will be immediately terminated for the Molina Medicare line of business.

**Social Security Administration (SSA) Death Master File**

Molina screens Provider names against the SSA Death Master File database during initial and recredentialing to ensure Provider are not fraudulently billing under a deceased person’s social security number. The names are also screened on a monthly basis to ensure there are no matches on the SSA Death Master File between credentialing cycles. If Molina identifies an exact match, the Provider will be immediately terminated for all lines of business effective the deceased date listed on the SSA Death Master File database.

**System for Award Management (SAM)**

Molina monitors the SAM once per month to ensure Providers have not been sanctioned. If a Molina Provider is found with a sanction, the Provider’s contract is immediately terminated effective the same date the sanction was implemented.
Program Integrity (Disclosure of Ownership/Controlling Interest)

Medicaid Managed Care health plans are required to collect specific information from network Providers prior to contracting and during credentialing to ensure that it complies with Federal regulations that require monitoring of Federal and State sanctions and exclusions databases. This monitoring ensures that any network Providers and the following details of any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against these sources, ensuring compliance with Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b). The categorical details required and collected are as follows:

1. Molina requires a current and complete Disclosure of Ownership and Control Interest Form during the credentialing process. Molina screens all individual names and entities listed on the form against the OIG, SAM, Medicare Opt-Out and each State’s specific Program Integrity Unit databases at the time of initial credentialing and recredentialing. These individual names and entities are also screened monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. This monitoring ensures that any individual/entity being contracted and those individuals/entities affiliated with the contractor are appropriately screened against Federal and State agency sources, ensuring compliance with 42 CFR §455. The following categorical details are collected and required on the Disclosure of Ownership and Control Interest during the credentialing and recredentialing process:
   a. Detailed identifying information for any individual who has ownership or controlling interest in the individual/entity being contracted if that individual has a history of criminal activity related to Medicaid, Medicare, or Title XX services (see 42 CFR §455.106).
   b. Detailed identifying information for all individuals who exercise operational or managerial control either directly or indirectly over daily operations and activities (see 42 CFR §455.101).
   c. Detailed identifying information for all individuals or entities that have a five percent (5%) or more ownership or controlling interest in the individual/entity being contracted (see 42 CFR §455.104).

2. Molina requires the Disclosure of Ownership and Control Interest Form be reviewed and re-attested to every thirty-six (36) months to ensure the information is correct and current.

3. Molina screens the entire contracted Provider network against the OIG, SAM, Medicare Opt-Out, each State’s specific Program Integrity Unit and Social Security Death Master File databases at initial credentialing and recredentialing, as well as, monthly for any currently sanctioned/excluded/terminated individuals or entities. Molina will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity.

4. Molina will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers. Molina will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.
5. If a State specific Program Integrity Unit notifies Molina an individual or entity is excluded from participation in Medicaid, Molina will terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately.

**Office Site and Medical Record Keeping Practices Review**

A review of office sites where you see Molina Members may be required. This review may be scheduled as soon as the Credentialing Department receives your application. This may also include a review of your medical record keeping practices. A passing score is required to complete the application process. Your cooperation in working with the site review staff and implementing any corrective action plans will expedite a credentialing decision.

Office site and medical record keeping reviews may also be initiated if any Member complaints are received regarding the physical accessibility, physical appearance or adequacy of waiting room and examining room space.

**Range of Actions, Notification to Authorities and Provider Appeal Rights**

Molina uses established criteria in the review of Providers’ performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

**Range of Actions Available**

The Molina Credentialing Committee can take one of the following actions against Providers who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all Providers who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. If at any point a Provider fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the Provider may be given the opportunity to appeal this decision.

**Criteria for Denial or Termination Decisions by the Credentialing Committee**

The criteria used by the Credentialing Committee to make a decision to deny or terminate a Provider from the Molina network include, but are not limited to, the following:
1. The Provider's professional license in any State has or has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.

2. Provider has or has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct.

3. Provider has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any State or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the Provider to Molina Members.

4. Provider has or has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their Federal Drug Enforcement Agency (DEA) certificate or Registration.

5. Provider has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the Provider has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the Provider has complied with all such conditions, limitations, or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the Provider's practice.

6. Provider has or has ever had sanctions of any nature taken by any Governmental Program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency.

7. Provider has or has ever had any denials, limitations, suspensions or terminations of participation of privileges or surrendered privileges while under investigation by any health care institution, plan, facility or clinic.

8. Provider's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.

9. Provider has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.

10. Provider has or has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the Provider's professional conduct or the health, safety or welfare of Molina Members.
11. Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.

12. Provider has or has ever had a pattern of Member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina Members.

13. Provider has not complied with Molina’s quality assurance program.

14. Provider is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.

15. Provider has or has ever displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.

16. Provider makes or has ever made any material misstatements in or omissions from their credentialing application and attachments.

17. Provider has ever rendered services outside the scope of their license.

18. Provider has or has ever had a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.

19. Provider has or has ever failed to comply with the Molina Medical Record Review Guidelines.

20. Provider has or has ever failed to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

Monitoring Providers Approved on a ‘Watch Status’ by the Committee

Molina uses the credentialing category “watch status” for Providers whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a Provider to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the Provider needs to be monitored for any reason.

When a Provider is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the Molina Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and recommendation.

Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the Provider to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:
• Identifying the performance issues that do not meet expectations
• What actions/processes will be implemented for correction
• Who is responsible for the corrective action
• What improvement/resolution is expected
• How improvements will be assessed
• Scheduled follow-up, monitoring (compliance review, normally not to exceed six (6) months)

Within ten (10) calendar days of the Credentialing Committee’s decision to place Provider on a corrective action plan, the Provider will be notified via a certified letter from the Medical Director. Such notification will outline:

• The reason for the corrective action
• The corrective action plan

If the corrective actions are resolved, the Provider’s performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the Provider continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate Provider response to corrective action will be brought to the Credentialing Committee for review and decision.

Summary Suspension

In cases where the Credentialing Committee or the Medical Director becomes aware of circumstances that pose an immediate risk to patients, the Provider may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the Provider of the suspension by written notification sent via certified letter. Notification will include the following:

• A description of the action being taken.
• Effective date of the action.
• The reason(s) for the action and/or information being investigated.
• Information (if any) required from the Provider.
• The length of the suspension.
• The estimated timeline for determining whether or not to reinstate or terminate the Provider.
• Details regarding the Providers right to request a fair hearing within thirty (30) calendar days of receipt of the notice and their right to be represented by an attorney or another person of their choice (see Fair Hearing Plan policy).
• If the Provider does not request a fair hearing within the thirty (30) calendar days, they have waived their rights to a hearing.
The action will be reported to the NPDB if the suspension is in place longer than thirty (30) calendar days.

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the Provider’s continued participation, discontinue the suspension or terminate the Provider.

Denial
After review of appropriate information, the Credentialing Committee may determine that the Provider should not be approved for participation in the Molina network. The Credentialing Committee may then vote to deny the Provider.

The Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee’s decision, the Provider is sent a written notice of denial via certified mail, from the Medical Director, which includes the reason for the denial.

Termination
After review of appropriate information, the Credentialing Committee may determine that the Provider does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the Provider.

Terminations for Reasons Other Than Unprofessional Conduct or Quality of Care
If the termination is based on reasons other than unprofessional conduct or quality of care, the Provider will not be reported to the NPDB and will not be given the right to a fair hearing. Within ten (10) calendar days of the Committee’s decision, the Provider is sent a written notice of termination via certified mail, from the Medical Director, which includes the following:

1. A Description of the action being taken
2. Reason for termination

Terminations Based on Unprofessional Conduct or Quality of Care
If the termination is based on unprofessional conduct or quality of care, the Provider will be given the right to a fair hearing.

Within ten (10) calendar days of the Committee’s decision, the Provider is sent a written notice of Molina’s intent to terminate them from the network, via certified mail from the Medical Director, which includes the following:

- A Description of the action being taken.
- Reason for termination.
• Details regarding the Provider’s right to request a fair hearing within thirty (30) calendar days of receipt of notice (see Fair Hearing Plan policy). The Fair Hearing Policy explains that Molina will appoint a hearing officer and a panel of individuals to review the appeal.
• The Provider does not request a fair hearing within the thirty (30) calendar days; they have waived their rights to a hearing.
• The notice will include a copy of the Fair Hearing Plan Policy describing the process in detail.
• Provider’s right to be represented by an attorney or another person of their choice.
• Obligations of the Provider regarding further care of Molina Patients/Members.
• The action will be reported to the NPDB and the State Licensing Board.

Molina will wait thirty (30) calendar days from the date the terminated Provider received the notice of termination. If the Provider requests a fair hearing within that required timeframe, Molina will follow the Fair Hearing Plan Policy. Once the hearing process is completed, the Provider will receive written notification of the appeal decision which will contain specific reasons for the decision (see Fair Hearing Plan Policy). If the hearing committee’s decision is to uphold the termination, the action will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below. If the hearing committee overturns the termination decision and the Provider remains in the Molina network, the action will not be reportable to the State Licensing Board or to the NPDB.

If the Provider does not request a hearing within the thirty (30) calendar days, they have waived their rights to a hearing and the termination will become the final decision. A written notification of the final termination will be sent to the Provider and the termination will be reported to the State Licensing Board and the NPDB as defined in reporting to appropriate authorities section below.

**Reporting to Appropriate Authorities**

Molina will make reports to appropriate authorities as specified in the Molina Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Provider based upon Unprofessional Conduct or quality of care. Adverse Actions include:

• Revocation, termination of, or expulsion from Molina Provider status.
• Summary Suspension in effect or imposed for more than thirty (30) calendar days.
• Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

Within fifteen (15) calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:

• All appropriate State licensing agencies
• National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate State licensing boards describing the adverse action taken, the Provider it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate State licensing boards within twenty-four (24) hours of receiving the final NPDB report. A copy of this letter is filed into the Provider’s credentials file. The action is also reported to other applicable State entities as required.
**Fair Hearing Plan Policy**

Under State and Federal Law, certain procedural rights shall be granted to a Provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board and the National Practitioner Data Bank (NPDB).

Molina Healthcare, Inc., and its Affiliates (“Molina”), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina will result in a report to the State Licensing Board and the NPDB.

**Definitions**

1. **Adverse Action** shall mean an action that entitles a Provider to a hearing, as set forth in Section B (1)-(3) below.

2. **Chief Medical Officer** shall mean the Chief Medical Officer for the respective Molina Affiliate State plan wherein the Provider is contracted.

3. **Days** shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.

4. **Medical Director** shall mean the Medical Director for the respective Molina Affiliate State plan wherein the Provider is contracted.

5. **Molina Plan** shall mean the respective Molina Affiliate State plan wherein the Provider is contracted.

6. **Notice** shall mean written notification sent by certified mail, return receipt requested, or personal delivery.

7. **Peer Review Committee or Credentialing Committee** shall mean a Molina Plan committee or the designee of such a committee.

8. **Plan President** shall mean the Plan President for the respective Molina Affiliate State plan wherein the Provider is contracted.

9. **Provider** shall mean physicians, dentists, and other health care Practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).

10. **State** shall mean the licensing board in the State in which the Provider practices.

11. **State Licensing Board** shall mean the State agency responsible for the licensure of Provider.

12. **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.

**Grounds for a Hearing**

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board and the NPDB.

2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina Members when such suspension, reduction, limitation, or revocation is reportable to the State Licensing Board and the NPDB.

3. Any other final action by Molina that by its nature is reportable to the State Licensing Board and the NPDB.

**Notice of Action**

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the Provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;

2. State any Credentialing Policy provisions that have been violated;

3. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;

4. Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;

5. Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.

6. Advise the Provider that the request for a hearing **must** be accompanied by a check in the amount of $1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;

7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal Law; and,

8. Provide a summary of the Provider’s hearing rights or attach a copy of this Policy.
9. Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the Provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the Provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A Provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the Provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the Provider’s waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

Appointment of a Hearing Committee

1. Composition of Hearing Committee

The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject Provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a Member of the panel.

The panel shall consist of three or more Providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected Provider. In the event Providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:

a. Evaluate evidence and testimony presented.
b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.

c. Maintain the privacy of the hearing unless the Law provides to the contrary.

4. Vacancies

   In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

   Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives. The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

Hearing Officer

1. Selection

   The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

   The Hearing Officer shall have the sole discretion and authority to:

   a. Exclude any witness, other than a party or other essential person.
   b. Determine the attendance of any person other than the parties and their counsel and representatives.
   c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee’s own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

   The Hearing Officer shall:

   a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
   b. Ensure that proper decorum is maintained;
   c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
   d. Issue rulings pertaining to matters of Law, procedure and the admissibility of evidence;
e. Issue rulings on any objections or evidentiary matters;
f. Discretion to limit the amount of time;
g. Assure that each witness is sworn in by the court reporter;
h. May ask questions of the witnesses (but must remain neutral/impartial);
i. May meet in private with the panel members to discuss the conduct of the hearing;
j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and,
l. Prepare the written report.

Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give notice to the affected Provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:

1. The date, time and location of the hearing.
2. The name of the Hearing Officer.
3. The names of the Hearing Committee Members.
4. A concise statement of the affected Provider’s alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.
6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing
Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

Pre-Hearing Procedures

1. The Provider shall have the following pre-hearing rights:
   a. To inspect and copy, at the Provider’s expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and,
   b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.

2. The Hearing Committee shall have the following pre-hearing right:
   To inspect and copy, at Molina’s expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.

3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:
   a. Whether the information sought may be introduced to support or defend the charges;
   b. The exculpatory or inculpatory nature of the information sought, if any;
   c. The burden attendant upon the party in possession of the information sought if access is granted; and,
   d. Any previous requests for access to information submitted or resisted by the parties.

4. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

5. It shall be the duty of the Provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.
7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

8. Conduct of Hearing

9. Rights of the Parties

Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

a. Call and examine witnesses for relevant testimony.
b. Introduce relevant exhibits or other documents.
c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
d. Otherwise rebut evidence.
e. Have a record made of the proceedings.
f. Submit a written statement at the close of the hearing.
g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

10. The Provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

11. Course of the Hearing

a. Each party may make an oral opening statement.
b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
c. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

12. Use of Exhibits

a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
b. A description of the exhibits in the order received shall be made a part of the record.

13. Witnesses

a. Witnesses for each party shall submit to questions or other examination.
b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.

c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.

d. The party producing such witnesses shall pay the expenses of their witnesses.

14. Rules for Hearing:

a. Attendance at Hearings
   Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee
   There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter
   Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.

2. A description of the hearing, including:
   a. The panel members’ names and specialties;
   b. The Hearing officer’s name;
   c. The date of the hearing;
   d. The charges at issue; and,
   e. An overview of witnesses heard and evidence.
3. The findings and recommendations of the Hearing Committee.

4. Any dissenting opinions desired to be expressed by the hearing panel members.

5. Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

**Burden of Proof**

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the Provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term “reasonable and warranted” means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

**Provider Failure to Appear or Proceed**

Failure, without good cause, of the Provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

**Record of the Hearing/Oath**

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

**Representation**

Each party shall be entitled to representation by an attorney at Law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

**Postponements**
The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

**Notification of Finding**

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee’s decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected Provider.

**Final Decision**

Upon receipt of the Hearing Committee’s decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee’s decision. The Chief Medical Officer/Plan President’s action constitutes the final decision.

**Reporting**

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board and the NPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

Reports to the State Licensing Board and the NPDB for adverse actions must be submitted within fifteen (15) days from the date the adverse action was taken.

**Exhaustion of Internal Remedies**

If any of the above Adverse Actions are taken or recommended, the Provider must exhaust the remedies afforded by this Policy before resorting to legal action.

**Confidentiality and Immunity**

Information regarding any Provider submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care shall, to the fullest extent permitted by Law, be confidential and shall only be disseminated to a Representative in order to carry out appropriate activities under these Policies and Procedures. Confidentiality shall also extend to such information that is provided by third parties.

For purposes of this section a “Representative” shall mean any individual authorized to preform specific information gathering or disseminating functions for the purpose of evaluating, improving, achieving or maintaining quality and cost effective patient care.

For purposes of this section “information” may be any written or oral disclosures including, but not limited to, a Provider’s professional qualifications, clinical ability, judgment, character, physical or mental health,
emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care or Provider’s provision of patient care services.

By providing patient care services at Molina, a Provider:

1. Authorizes representatives of Molina to solicit, provide, and act upon information bearing on the Provider’s qualifications.

2. Agrees to be bound by the provisions of this policy and procedure and to waive all legal claims against any representative who acts in accordance with the provisions of this policy and procedure.

3. Acknowledges that the provisions of this policy and procedure are express conditions of the application for, or acceptance of, Molina membership and the continuation of such membership, and to the exercise of clinical privileges or provision of Patient care.

The confidentiality and immunity provisions of this policy and procedure shall apply to all information so protected by State or Federal Law. To the fullest extent permitted by State or Federal Law, the confidentiality and immunity provisions of this policy and procedure shall include, but is not limited to:

1. Any type of application or reapplication received by the Provider;

2. Actions reducing, suspending, terminating or revoking a Provider’s status, including requests for corrective actions, investigation reports and documents and all other information related to such action;

3. Hearing and appellate review;

4. Peer review and utilization and quality management activities;

5. Risk management activities and Claims review;

6. Potential or actual liability exposure issues;

7. Incident and/or investigative reports;

8. Claims review;

9. Minutes of all meetings by any committees otherwise appropriately appointed by the Board;

10. Any activities related to monitoring the quality, appropriateness or safety of health care services;

11. Minutes of any Committees and Subcommittees related to monitoring the quality, appropriateness or safety of health care services;

12. Any Molina operations and actions relating to Provider conduct.
Immunity from Liability for Action Taken: No representative shall be liable to a Provider or any third party for damages or other relief for any decision, opinion, action, statement, or recommendations made within the scope of their duties as representative, if such representative acts in good faith and without malice.

Immunity from Liability for Providing Information: No representative or third parties shall be liable to a Provider for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any third party pursuant to authorization by the Provider, or if permitted or required by Law, or these Policies and Procedures, provided that such representative or third parties acts in good faith and without malice.

Cumulative Effect: The provisions in this Policy and Procedure and any forms relating to authorizations, confidentiality of information, and immunities from liability are in addition to other protections provided by relevant State and Federal Law, and are not a limitation thereof.

**Managed Medical Assistance: Complaints, Grievance and Appeals Process**

Molina Healthcare Members or Member’s personal representatives have the right to file a complaint, grievance and submit an appeal through a formal process. This section addresses the identification, review and resolution of Member grievances and appeals. Below are Molina Healthcare’s Member Grievance and Appeals Process.

**Member Complaints, Grievance & Appeals Process**

If a Member is unhappy with the service from Molina Healthcare or providers contracted with Molina Healthcare, they may file a complaint or a formal grievance by contacting Member Services toll-free at (866) 472-4585, Monday – Friday 8 a.m. – 7 p.m. They can also write to us at:

**Molina Healthcare of Florida**  
**Attention: Grievance & Appeals Department**  
P.O. Box 521838  
Miami, FL 33152

Members may also send their written grievance via fax to: (877) 508-5748 or submit via email at: MFLGrievanceandAppeals@MolinaHealthcare.com

Members are notified of their grievance and appeal rights and the different levels of grievances and appeals through various general communications including, but not limited to, the Member handbook, Member newsletters and Molina Healthcare’s website: www.molinahealthcare.com. Members are notified of these rights upon enrollment, and annually thereafter.

Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage during the grievance and appeals process. If under applicable law, a person has authority to act on behalf of a Member in making decisions related to health care or is a legal representative of the Member, MHF will treat such person as a personal representative.
If the Member/Provider registers an informal complaint, Molina Healthcare will attempt to resolve the complaint within 24 hours. If the complaint cannot be resolved, it will be treated as a formal grievance. A member may file a grievance orally or in writing at any time.

A member, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination.

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

All grievances whether oral or in writing, and Appeals (oral, followed by written confirmation within five (5) days of) are documented by the Member Services Department in all appropriate systems, and written acknowledgement is sent to all parties.

Any issues related to a clinical denial and/or appeal of a coverage decision, is referred to the Utilization Management Department to review the medical necessity aspects of the request.

A person not involved in the previous decision-making process reviews the grievance or appeal to determine the resolution. In appeals involving denial of clinical services, health care professionals with appropriate expertise conduct the review. A Medical Director of same or similar specialty who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination will review the appeal and make the determination.

All grievance and appeal requests concerning admissions, continued stay, immediate care issues, or other services for Members who have received emergency services but have not been discharged from a facility are granted an Expedited Review. Expedited Reviews are completed as promptly as the medical condition requires, but no later than three (3) days after the request.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) and/or Critical Incidents issues is referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.

All grievance decisions are made within state established time frames not to exceed ninety (90) calendar days from the day the initial grievance or appeal is received. However, the grievance process time-frame may be extended up to fourteen (14) calendar days if the Member voluntarily agrees to an extension or the Managed Care Plan documents that additional information is needed and the delay is in the enrollee’s interest. If the timeframe is extended other than at the enrollee’s request, the Managed Care Plan shall notify the enrollee within five (5) business days of the determination, in writing, of the reason for the delay. All appeal decisions are made within state established time frames not to exceed thirty (30) calendar days from the day the initial grievance or appeal is received. However, the appeal process time-frame may be extended up to (14) calendar days if the Member voluntarily agrees to an extension.
All aspects of the review process are documented and tracked in Molina Healthcare’s core data maintenance application and Grievance and Appeal database.

Members also have the right to appear in person and/or appoint a representative to act and speak on the Member’s behalf at any point in the grievance and appeals process.

A member who has completed the Managed Care Plan’s appeal process may file for a Medicaid Fair Hearing within one hundred twenty (120) calendar days of receipt of the notice of plan appeal resolution. To request a Fair Hearing, Members/Member representative, should contact:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

Phone: (877) 254-1055
Fax: (239) 338-2642
MedicaidHearingUnit@ahca.myflorida.com

If a Member is not satisfied with Molina Healthcare’s decision of their grievance or appeal they may request a review by the Subscriber Assistance Program (SAP). The Member has one year from receipt of the decision letter to request a review. If the Member files a Medicaid Fair Hearing on their case, they forfeit the right to a SAP review of their case. To request a review by SAP, Members/Member representatives should contact:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, FL 32308

Direct: 1-850-412-4502
Toll Free: 1-888-419-3456

Molina Healthcare shall continue the Member’s benefits if the Member or the Member’s authorized representative submits a request for appeal within ten (10) business days after the Notice of Adverse Benefit Determination is mailed, or on or before the intended effective date of the action, whichever is later.

If the final resolution of the appeal is adverse to the Member and the action is upheld, Molina Healthcare may recover the cost of services furnished to the Member while the appeal was pending to the extent they were furnished solely because of the continuation of benefits requirement.
**Expedited Appeal**

An appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a Member’s life or materially jeopardize a Member’s health. A request to expedite may come from the Member, a provider, or when Molina Healthcare feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within seventy-two (72) hours.

**Reporting**

All Grievance/Appeal data, including practitioner specific data, is reported quarterly to Member/Provider Satisfaction Committee (MPSC) by the Department Managers for review and recommendation. A Summary of the results is reported to the Executive Quality Improvement Committee quarterly. Annually, a quantitative/qualitative report will be compiled and presented to 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.

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

**Record Retention**

Molina Healthcare will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically in Molina Healthcare’s core processing system or maintained in other electronic files, Molina Healthcare will retain copies of any written documentation submitted by the provider pertaining to the grievance/appeal process.

**Second Opinion**

If a Member does not agree with their provider’s plan of care, they have the right to a second opinion from another provider. Member can call Member Services to find out how to get a second opinion.

**Provider Complaint Process**

**Provider Disputes and Appeals**

Molina Healthcare is committed to the timely resolution of all provider complaints. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. A written request by a provider received at Molina Healthcare for review of an action is considered a Provider Appeal.

**Provider Claims Disputes**

Providers disputing a Claim previously adjudicated must request such action within one (1) year 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 Provider Dispute/Appeal Form 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, secure email or mail. Claims Disputes/Reconsideration requested via the Provider Dispute/Appeal Form may be sent to the following address:

Molina Healthcare of Florida, Inc.
Attention: Grievance & Appeals Department
PO Box 527450
Miami, Florida 33152-7450

Submitted via fax:
(877) 553-6504

Secure email:
MFL_ProviderAppeals@MolinaHealthcare.com

**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.

For claims related issues, the Provider will be notified of Molina’s decision in writing within sixty (60) days of receipt of the Claims Dispute/Adjustment request.

**Provider Complaints Not Related to Claims**

To file a Provider Complaint not related to claims, providers may contact Member Services at (866) 472-4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida, Inc.
Attention: Grievance & Appeals Department
PO Box 527450
Miami, Florida 33152-7450

Submitted via fax:
(877) 553-6504

Secure email:
Provider Complaints must be received within one (1) year of the date of payment or denial of the claim. All Provider Complaints will be reviewed confidentially by the Grievance and Appeals Department.

For non-claims related issues, the outcome will be communicated in writing within ninety (90) days of receipt of the Provider Dispute.

**Managed Medical Assistance: Delegation**

This section contains information specific to medical groups, Independent Practice Associations (IPA), and Vendors contracted with Molina to provide medical care or services to Members, and outlines Molina’s delegation criteria and capitation reimbursement models. Molina will delegate certain administrative responsibilities to the contracted medical groups, IPAs, or vendors, upon meeting all of Molina’s delegation criteria. Provider capitation reimbursement models range from fee-for-service to full risk capitation.

**Delegation of Administrative Functions**

Administrative services which may be delegated to IPAs, Medical Groups, Vendors, or other organizations include:

- Call Center
- Care Management
- Claims Administration
- Credentialing
- Non-Emergent Medical Transportation (NEMT)
- Utilization Management (UM)

Credentialing functions may be delegated to Capitated or Non-Capitated entities, which meet National Committee for Quality Assurance (NCQA) criteria for credentialing functions. Call Center, Claims Administration, Care Management and/or Utilization Management functions are generally only delegated to Vendors or full risk entities. Non-Emergent Medical Transportation (NEMT) may be delegated to Vendors who can meet Call Center, Claims Administration and/or NEMT requirements.

**Note:** The Molina Member’s ID card will identify which group the Member is assigned. If Claims Administration and/or UM has been delegated to the group, the ID card will show the delegated group’s remit to address and phone number for referrals and prior authorizations.

**Delegation Criteria**

Molina is accountable for all aspects of the Member’s health care delivery, even when it delegates specific responsibilities to sub-contracted IPAs, Medical Groups, or Vendors. Molina’s Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements.
Call Center
To be delegated for Call Center functions, Vendors must:

- Have a Vendor contract with Molina (Molina does not delegate call center functions to IPAs or Provider Groups).
- Have a Call Center delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Correct deficiencies within the timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste and Abuse.
- Must have an automated call system that allows the Vendor to confirm Member benefits and eligibility during the call.
- Agree to Molina’s contract terms and conditions for Call Center delegates.
- Submit timely and complete Call Center delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Current call center is able to demonstrate compliance with service level performance, average speed to answer, abandonment rate, and/or percentage of calls that are complaints meet CMS and/or state requirements, depending on the line(s) of business delegated.

A Vendor may request Call Center delegation from Molina through Molina’s Delegation Oversight Manager or through the Vendor’s 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 Call Center responsibilities is based on the Vendor’s ability to meet Molina, State and Federal requirements for delegation.

Care Management
To be delegated for Care Management functions, Medical Groups, IPAs and/or Vendors must:

- Be certified by the National Committee for Quality Assurance (NCQA) for complex case management and disease management programs.
- Have a current complex case management and disease management program descriptions in place.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
- Pass a care management pre-assessment audit, based on NCQA and State requirements, and Molina business needs.
- 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 care management delegates.
• Submit timely and complete Care Management delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
• Comply with all applicable federal and state Laws.

Note: Molina does not allow care management delegates to further sub-delegate care management activities.

A Medical Group, IPA, or Vendor may request Care Management delegation from Molina through Molina’s Delegation Oversight Manager or through the Medical Group, IPA, or Vendor’s 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 Care Management responsibilities is based on the Medical Group, IPA, or Vendor’s ability to meet Molina, State and Federal requirements for delegation.

Claims Administration
To be delegated for Claims Administration, Medical Groups, IPAs, and/or Vendors must do the following:

• Have a capitation contract with Molina and be in compliance with the financial reserves requirements of the contract.
• Be delegated for UM by Molina.
• Protect the confidentiality of all PHI as required by Law.
• Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
• Have a Claims Administration delegation pre-assessment completed by Molina to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
• Correct deficiencies within timeframes identified in the corrective action plan (CAP) when issues of non-compliance are identified by Molina.
• Must have an automated system capable of accepting electronic claims in an ICD 10 compliant format.
• Must have an automated system capable of providing Molina with the Encounter Data required by the state in a format readable by Molina.
• Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30) days.
• Agree to Molina’s contract terms and conditions for Claims Delegates.
• Submit timely and complete Claims Administration delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
• Within (10) days of the end of the month in which care was rendered, provide Molina with the Encounter Data required by the state in a format compliant with HIPAA requirements.
• Provide additional information as necessary to load Encounter Data within (30) days of Molina’s request.
• Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
• Comply with all applicable Federal and State Laws.
• When using Molina’s contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Molina’s Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.

A Medical Group, IPA, or Vendor may request Claims Administration delegation from Molina through Molina’s Delegation Oversight Manager or through the Medical Group, IPA, or Vendor’s 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 Claims Administration responsibilities is based on the Medical Group, IPA, or Vendor’s ability to meet Molina, State and Federal requirements for delegation.

**Credentialing**

To be delegated for credentialing functions, Medical Groups, IPAs, and/or Vendors must:

- Pass Molina’s credentialing pre-assessment, which is based on NCQA credentialing standards.
- Have a multi-disciplinary Credentialing Committee who is responsible for review and approval or denial/termination of practitioners included in delegation.
- Have an Ongoing Monitoring process in place that screens all practitioners included in delegation against OIG, SAM, and all published state Medicaid exclusion lists a minimum of every thirty days.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and staff of all levels against OIG and SAM lists prior to hire dates, and 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 Medical Group, IPA, or Vendor 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 Medical Group, IPA, or Vendor 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.

A Medical Group, IPA, or Vendor may request Credentialing delegation from Molina through Molina’s Delegation Oversight Manager or through the Medical Group, IPA, or Vendor’s 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 Medical Group, IPA, or Vendor’s ability to meet Molina, State and Federal requirements for delegation.

Non-Emergent Medical Transportation (NEMT)

To be delegated for NEMT functions, Vendors must do the following:

- Have a Vendor contract with Molina (Molina does not delegate NEMT functions to IPAs or Medical Groups).
- Pass Molina’s NEMT pre-assessment, which is based on State and Federal NEMT requirements.
- Have automated systems that allow for scheduling of NEMT appointments, confirmation of Member eligibility, and availability of NEMT benefits.
- Have processes in place to ensure protection of Member PHI.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a network of vehicles and drivers that meet State and Federal safety requirements.
- Ensure on at least an annual basis that vehicles continue to meet State and Federal vehicle safety requirements.
- Ensure that drivers continually meet State and Federal safety requirements.
- Have a process in place for reporting of all accidents, regardless of harm to Member, to Molina within forty-eight (48) hours.
- Agree to Molina’s contract terms and conditions for NEMT delegates, including applicable Call Center and/or Claims Administration delegation requirements.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are identified by Molina.
- Submit timely and complete NEMT delegation reports as detailed in the Delegated Services Addendum to the applicable Molina contact.
- Comply with all applicable Federal and State Laws.

Note: If the NEMT Vendor delegates to other sub-contractors, the NEMT Vendor must have a process to ensure that their sub-contractors meet all Health Plan and State and Federal requirements identified above. Evaluation should be done prior to execution of a contract, and annually thereafter. Evaluation should include review of compliance with driver requirements, vehicle requirements, Health Plan, State and Federal requirements, and a process to implement corrective action if issues of non-compliance are identified.

A Vendor may request NEMT delegation from Molina through Molina’s Delegation Manager or through the Vendor’s 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 DOC for review. Final decision to delegate NEMT is based on
the Vendor’s ability to meet Molina’s standards and criteria for delegation.

Utilization Management (UM)

To be delegated for UM functions, Medical Groups, IPAs, and/or Vendors must:

- Have a UM program that has been operational at least one year prior to delegation, and includes an
  annual UM Program evaluation and annual Inter Rater Reliability audits of all levels of UM staff.
- Pass Molina’s UM pre-assessment, which is based on NCQA, State and Federal UM standards, and
  Molina Policies and Procedures.
- Correct deficiencies within mutually agreed upon timeframes when issues of non-compliance are
  identified by Molina.
- Ensure that only licensed physicians/dentists medical necessity denial decisions.
- Ensure that only appropriate levels of clinical staff make medical necessity approval decisions.
- Have a screening process in place to review all Medical Group, IPA, and/or Vendor employees and
  staff of all levels against OIG and SAM lists prior to hire dates, and a minimum of every thirty (30)
  days.
- Agree to Molina’s contract terms and conditions for UM delegates.
- Submit timely and complete UM delegation reports as detailed in the Delegated Services Addendum
  to the applicable Molina contact.
- Comply with the standard Transactions and Code Sets requirements for authorization requests and
  responses using the formats required by HIPAA.
- Comply with all applicable federal and state Laws.

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

Molina does not allow UM delegates to further sub-delegate UM activities.

A Medical Group, IPA, or Vendor may request UM delegation from Molina through Molina’s Delegation
Oversight Manager or through the Medical Group, IPA, or Vendor’s 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 UM responsibilities is based on the Medical
Group, IPA, or Vendor’s ability to meet Molina, State and Federal requirements for delegation.
Quality Improvement/Preventive Health Activities

Molina does not delegate Quality Improvement activities to Provider organizations. Molina will include all network Providers, including those in Medical Groups, IPAs, or Vendors who are delegated for other functions (Claims, Credentialing, UM, etc.) in its Quality Improvement Program activities and preventive health activities. Molina encourages all contracted Provider organizations to conduct activities to improve the quality of care and service provided by their organization. Molina would appreciate receiving copies of studies conducted or data analyzed as part of the Medical Group, IPA, or Vendor’s Quality Improvement Program.

Delegation Reporting Requirements

Medical Groups, IPAs, or Vendors contracted with Molina and delegated for various administrative functions 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 Provider Services Contract Manager.

Managed Medical Assistance: Cultural Competency

Molina Healthcare maintains a Cultural Competency Plan to ensure the delivery of culturally competent services and the provision of linguistic access and disability-related access to all Members including those with limited English proficiency. The Cultural Competency Plan describes how the individuals and systems within Molina Healthcare will effectively provide services to people of all cultures, races, ethnic backgrounds 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.

The intent of the Cultural Competency Plan is to ensure the delivery of culturally competent services and provision of Linguistic Access and Disability-related Access to all enrollees including those with limited English Proficiency. The Cultural Competency Plan describes how individuals and systems within the Health Maintenance Organization (HMO) shall effectively provide services to people of all cultures, races, ethnic backgrounds, religions and or disabilities in order to improve quality and eliminate health care disparities.

The cultural competency program is integrated into overall provider orientation training and quality monitoring programs because the training of employees and providers, along with quality monitoring are the cornerstones of successful culturally competent service delivery. An integrated quality approach is aimed at enhancing 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

Providers, staff supporting providers and Community Based Organizations receive cultural competency training during provider orientation. Molina also offers free online CME program Continuing Medical Education (CME) courses that are accredited for CME credit (AAFP Prescribed credits approved).

Training is delivered through a variety of methods such as:
- Written materials – Provider Handbook
- Access to enduring reference materials available through the health plan
- Continuing Medical Education (CME)
- Educational Materials and Electronic Library (Diverse Populations Care)

Providers may visit our website to obtain a summary or the full version of this plan; or can request a hard copy at no cost by contacting Provider Services at (855) 322-4076.
Communication Access
Molina Healthcare offers various oral and written translation services to assist members in communicating with providers, Molina Customer Service representatives and case managers. These services include:

- Oral and written translation services for members with low English proficiency
- Sign Language interpretation services for the hearing impaired
- Member materials in Spanish, Braille or in audio format

Providers may request interpreter services for any Molina Healthcare member, at no cost to the provider or the member, by calling Customer Service at (855) 322-4076. The hearing impaired may use our TTY line (800) 955-8771.

Program and Policy Review Guidelines
Molina Healthcare will assess the following information yearly in order to ensure its programs are most effectively meeting the needs of its members and providers.

Molina monitors complaints in respect to member satisfaction in the area of cultural and linguistic needs in an effort to ensure that each is adequately addressed in a timely manner. The Plan will implement performance intervention measures as well as studies in an effort to identify and improve processes and/or outcomes of health care or services.

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local geographic population demographics and trends derived from publicly available sources (Group Needs Assessment) as available
- Network Assessment annually
- Applicable national demographics and trends derived from publicly available sources
- Health status measures such as those measured by HEDIS as available
- Comparison with selected measures such as those in Healthy People 2010
- Annual Measures available through national testing programs such as the National Health and Nutrition Examination Survey (NHANES)
- CAHPS® Results (annually)
- Provider Satisfaction Survey Results (annually)
- PIP Cultural and Linguistic Access to Services

******************************************************************************END OF MMA******************************************************************************
Long-Term Care Providers
Long-Term Care Overview

Medicaid is the medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C. §1396 et seq., and regulations thereunder, as administered in the State of Florida by the Agency under s. 409.901 et seq., F.S. It is the state and federal system of health insurance that provides health coverage for those requiring financial assistance or of low income.

The Statewide Medicaid Managed Care (SMMC) program consists of two components: Florida Managed Medical Assistance Program and Florida Long Term Care Managed Care Program. Medicaid recipients who qualify and become enrolled in the Florida Long Term Care Managed Care Program will receive long term care services that will be managed through a case manager of the health plan. The health plan will work with different providers to offer quality health care services and to ensure enrollees have access to covered services as needed. Medicaid recipients who qualify and become enrolled in the Florida Managed Medical Assistance Program will receive all health care services with the exception of long term care.

Program Goals

Molina Healthcare of Florida Community Plus program’s goals are:

- Keep members safely in the community in the lease restrictive environment possible.
- Preserve the member’s dignity and promote the member’s autonomy
- Improve members’ functional independence and quality of life
- Ensure quality of care by utilizing best practice guidelines with providers
- Prevent hospitalization, emergency room visits, and nursing facility placement
- Coordinate palliative care and hospice
- Support caregivers with disease management tools, appropriate respite care and education about special needs, such as Dementia/Alzheimer’s
Long-Term Care: Addresses and Phone Numbers

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member claims, benefits, eligibility/identification, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8:00 AM to 7:00 PM EST/EDT Monday through Friday, excluding State holidays.

<table>
<thead>
<tr>
<th>Member Services</th>
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<tbody>
<tr>
<td>Address:</td>
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<tr>
<td>Molina Healthcare of Florida</td>
</tr>
<tr>
<td>Community Plus Program</td>
</tr>
<tr>
<td>8300 NW 33rd Street, Suite 400</td>
</tr>
<tr>
<td>Doral, FL 33122</td>
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<tr>
<td>Phone:</td>
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<tr>
<td>(866) 472-4585</td>
</tr>
<tr>
<td>TTY:</td>
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<tr>
<td>(800) 955-8771 (English)</td>
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<tr>
<td>(800) 955-8773 (Spanish)</td>
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Claims Department

The Claims Department is located at our corporate office in Long Beach, CA. Molina requires Participating Providers to submit Claims electronically (via a clearinghouse or Molina's Provider Portal). Electronically filed claims must use EDI Claims/Payor ID number - 51062.

To verify the status of your claims, please visit the Provider Portal or call our Provider Claims Representatives at the numbers listed below.

<table>
<thead>
<tr>
<th>Claims</th>
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<tbody>
<tr>
<td>Phone:</td>
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<tr>
<td>(855) 322-4076</td>
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<td>TTY:</td>
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<td>(800) 955-8771 (English)</td>
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<td>(800) 955-8773 (Spanish)</td>
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<tr>
<th>Provider Portal</th>
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<td><a href="https://provider.molinahealthcare.com">https://provider.molinahealthcare.com</a></td>
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Claims Recovery Department

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

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<thead>
<tr>
<th>Claims Recovery</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida Community Plus Program PO Box 22812 Long Beach, CA 90801</td>
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<tr>
<td>Phone: (866) 642-8999</td>
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</table>

Credentialing Department

The Credentialing Department verifies all information on the Practitioner 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 Healthcare network. The Credentialing Department also performs office and medical record reviews.

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<thead>
<tr>
<th>Credentialing</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida 8300 NW 33rd Street, Suite 400 Doral, FL 33122</td>
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<tr>
<td>Phone: (855) 322-4076</td>
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<tr>
<td>Fax: (866) 422-6445</td>
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</table>
Health Line (24-Hour Nurse Advice Line)

This telephone-based nurse advice line is available to all Molina Healthcare 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.

<table>
<thead>
<tr>
<th>Health Line (24-Hour Nurse Advise Line)</th>
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<tbody>
<tr>
<td>English Phone: (888) 275-8750</td>
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<tr>
<td>Spanish Phone: (866) 648-3537</td>
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<tr>
<td>TTY: (866) 735-2929 (English)</td>
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Healthcare Services Department

The Healthcare Services Department conducts concurrent review on inpatient cases and processes Prior Authorization requests.

<table>
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<tr>
<th>Healthcare Services Authorizations &amp; Inpatient Census</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
</tr>
<tr>
<td>8300 NW 33rd Street,</td>
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<tr>
<td>Suite 400</td>
</tr>
<tr>
<td>Doral, FL 33122</td>
</tr>
<tr>
<td>Phone: (855) 322-4076</td>
</tr>
<tr>
<td>Fax: (866) 440-4791 (Medicaid)</td>
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</table>
Health Education & Health Management Department

The Health Education and Health Management Department provides education and health information to Molina Healthcare Members and facilitates Provider access to the programs and services.

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<tr>
<th>Health Education &amp; Management</th>
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<tr>
<td>Address: Molina Healthcare of Florida</td>
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<tr>
<td>8300 NW 33rd Street, Suite 400</td>
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<td>Doral, FL 33122</td>
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<td>Phone: (855) 322-4076</td>
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<tr>
<td>Fax: (866) 422-6445</td>
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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 serving all Molina Healthcare of Florida’s provider network.

<table>
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<tr>
<th>Provider Services</th>
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<tbody>
<tr>
<td>Address: Molina Healthcare of Florida</td>
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<tr>
<td>8300 NW 33rd Street, Suite 400</td>
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<tr>
<td>Doral, FL 33122</td>
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<tr>
<td>Phone: (855) 322-4076</td>
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<tr>
<td>Fax: (866) 948-3537</td>
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Compliance Department

Molina Healthcare’s Compliance Department can be reached at the number provided below:

<table>
<thead>
<tr>
<th>Compliance Hotline</th>
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<tr>
<td>Phone: (866) 642-9510</td>
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</table>
Abuse, Neglect and Exploitation Hotline

To report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult, please contact the Florida Abuse Hotline toll-free telephone number.

<table>
<thead>
<tr>
<th>Florida Abuse Hotline</th>
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<tr>
<td>(800)-96ABUSE or (800)-962-2873</td>
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Long-Term Care: Enrollment and Eligibility

Eligible recipients age eighteen (18) years or older in any of the following programs or eligibility categories are required to enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

1. Temporary Assistance to Needy Families (TANF);
2. SSI (Aged, Blind and Disabled);
3. Institutional Care;
4. Hospice;
5. Individuals who age out of Children’s Medical Services and meet the following criteria:
   a. Received care from Children’s Medical Services prior to turning age twenty-one (21) years;
   b. Age twenty-one (21) years and older;
   c. Cognitively intact;
   d. Medically complex; and
   e. Technologically dependent.
6. Low Income Families and Children;
7. MEDS (SOBRA) for children born after 9/30/83 (age eighteen (18) through twenty (20) years);
8. MEDS AD (SOBRA) for aged and disabled;
(9) Protected Medicaid (aged and disabled);
(10) Full Benefit Dual Eligibles (Medicare and Medicaid);
(11) Individuals enrolled in the Frail/Elderly Program component of United Healthcare HMO; and
(12) Medicaid Pending for Long-term Care Managed Care HCBS waiver services.

**Voluntary Enrollment**

Eligible recipients eighteen (18) years or older in any of the following eligibility categories may, but are not required to, enroll in a Managed Care Plan if they have been determined by CARES to meet the nursing facility level of care:

a. Traumatic Brain and Spinal Cord Injury waiver;

b. Project AIDS Care (PAC) waiver;

c. Adult Cystic Fibrosis waiver;

d. Program of All-Inclusive Care for the Elderly (PACE) plan members;

e. Familial Dysautonomia waiver;

f. Model waiver (age eighteen (18) through twenty (20) years);

g. Developmental Disabilities waiver (iBudget and Tiers 1-4);

h. Medicaid for the Aged and Disabled (MEDS AD) — Sixth Omnibus Budget Reconciliation Act (SOBRA) for aged and disabled — enrolled in Developmental Disabilities (DD) waiver; and

i. Recipients with other creditable coverage excluding Medicare.

**Excluded Population**

Regardless of eligibility category, the following recipients are excluded from enrollment in a Comprehensive LTC Managed Care Plan:

(1) Recipients residing in residential commitment facilities operated through DJJ or treatment facilities as defined in s. 394.455(47), F.S.;

(2) Recipients residing in DD centers including Sunland and Tacachale;

(3) Children receiving services in a prescribed pediatric extended care center (PPEC);

(4) Children with chronic conditions enrolled in the Children’s Medical Services Network; and

(5) Recipients in the Health Insurance Premium Payment (HIPP) program.
Long-Term Care: Provider Responsibilities

- Provide all services in an ethical, legal, culturally competent manner, free of discrimination against members based on age, race, creed, color, religion, gender identity, national origin, sexual orientation, marital, physical, mental, or socio-economic status
- Participate in and cooperate with Quality Improvement, Utilization Review, and other similar programs established by Molina Healthcare of Florida
- Participate in and cooperate with Molina Healthcare of Florida’s grievance procedures
- Never balance bill Molina Healthcare of Florida members
- Comply with all federal and state laws regarding confidentiality of member records
- Participate in and cooperate with Molina Healthcare of Florida’s Quality Management program to ensure the delivery of quality care in the most cost effective manner
- Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services
- Immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free telephone number, (800) 96ABUSE
- Maintain communication with appropriate agencies, such as local police, poison control, and social service agencies to ensure members receive quality care
- Contact a Molina Healthcare case manager if a member exhibits a significant change, is admitted to a hospital or hospice program.

Long-Term Care: Abuse, Neglect, and Exploitation

All Molina Healthcare direct service providers must complete Abuse, Neglect, and Exploitation Training. This training may be provided by the Department of Children and Families, the local area agency on aging, the Department of Elder Affairs, or through licensing requirements.

Department of Children and Families
1317 Winewood Blvd
Bldg 5 – Room 203
Tallahassee, FL 32399-077
Phone: (850)-488-1429

“Abuse” means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee’s physical, mental, or emotional health. Abuse includes acts and omissions.
“Exploitation” of a vulnerable adult means a person who:

1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by
deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable
adult’s funds, assets, or property for the benefit of someone other than the vulnerable
adult.

2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains
or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets, or property
with the intent to temporarily or permanently deprive the vulnerable adult of the use,
benefit, or possession of the funds, assets, or property for the benefit of someone other
than the vulnerable adult.

“Neglect” of an adult means the failure or omission on the part of the caregiver to provide the
care, supervision, and services necessary to maintain the physical and behavioral health of the
vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and
medical services, that a prudent person would consider essential for the well-being of the
vulnerable adult. The term “neglect” also means the failure of a caregiver to make a reasonable
effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. “Neglect” is
repeated conduct or a single incident of carelessness that produces, or could reasonably be
expected to result in, serious physical or psychological injury or a substantial risk of death.

“Neglect” of a child occurs when a child is deprived of, or is allowed to be deprived of, necessary
food, clothing, shelter, or medical treatment, or a child is permitted to live in an environment
when such deprivation or environment causes the child’s physical, behavioral, or emotional
health to be significantly impaired or to be in danger of being significantly impaired.

Providers must immediately report knowledge or reasonable suspicion of abuse, neglect, or
exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline toll-free
telephone number, (800) 96ABUSE. Additionally, providers must report adverse incidents
including events involving abuse, neglect, exploitation, major illness or injury, involvement with
law enforcement, elopement/missing, or major medication incidents to Molina Healthcare no
more than twenty-four (24) hours of the incident.

The Critical Incident Form is located on Molina Healthcare’s website at:

http://www.molinahealthcare.com/providers/fl/medicaid/forms/Pages/fuf.aspx

To report a critical incident, provider should email the Critical Incident Form to:

MFLQIAlerts@MolinaHealthCare.Com

Identifying Victims of Human Trafficking

For specific information regarding indications of Human Trafficking, please refer to the Florida
Department of Children and Families at:
Provider Support

Molina Healthcare of Florida recognizes the importance of communication with its network providers, and offers various tools and resources to ensure access to the most-up-to date Molina Healthcare of Florida Community Plus Program information. Providers may visit our website for member eligibility, claims status, or to download handbooks and forms. Hard copies of the handbook are available to all providers, at no charge. Contact Provider Services for a copy.

Providers may also call Provider Services and speak with a representative who will address any questions or concerns:

Provider Services Toll-Free Line: (855) 322-4076
On the web: www.molinahealthcare.com

Long-Term Care: Provider Complaints

Molina Healthcare of Florida Provider Services representatives are available to assist providers with any issues or concerns regarding the administration of services. Most issues and complaints can be resolved promptly by calling Provider Services at (855) 322-4076 between the hours of 8:30 a.m. to 5:00 p.m., Monday through Friday.

Contracted providers may also register formal complaints at any time, to express dissatisfaction with a Molina Healthcare policy, procedure, administrative function or for any other reason a provider deems appropriate. Complaints, unrelated to claims, may be reported by phone or in writing, within 45 days of the occurrence prompting the complaint. For claims complaints, please refer to Long-Term Care: Provider Complaint Process section in this Handbook.

To register a complaint by phone, contact Customer Service at (855) 322-4076.

To register a complaint in writing, send the written request to:

Molina Healthcare of Florida
Attention: Grievance & Appeals Department
PO Box 527450
Miami, Florida 33152-7450
or
MFL_ProviderAppeals@MolinaHealthcare.com

Providers may also send their written complaints via fax to: (877) 553-6504

All complaints are acknowledged within 3 days of receipt, and reviewed confidentially by the Grievance and Appeals Department, using applicable statutory, regulatory and contractual provisions. Most complaints may be resolved immediately. However, if an immediate resolution is not possible, the resolution will be made as expeditiously as is possible, but will not exceed
ninety (90) days of receipt of the complaint. The resolution of the complaint is communicated within three (3) business days.

Long-Term Care: HIPAA

HIPAA - The Health Insurance Portability and Accountability Act

Molina Healthcare’s Commitment to Patient Privacy

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

Provider/Practitioner Responsibilities

Molina Healthcare expects that its contracted Providers/Practitioners will respect the privacy of Molina Healthcare members and comply with all applicable laws and regulations regarding the privacy of patient and member PHI.

Providers must 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. Providers must ensure their staff receives periodic training regarding the confidentiality of Member information.

Applicable Laws

Providers/Practitioners must understand all state and federal healthcare 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/Practitioners must comply with. In general, most healthcare Providers/Practitioners are subject to various laws and regulations pertaining to privacy of health information including, without limitation, the following:

1. Federal Laws and Regulations
   • HIPAA
   • Medicare and Medicaid laws

2. Applicable State of Florida Laws and Regulations

Providers/Practitioners should be aware that HIPAA provides a floor for patient privacy but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers/Practitioners 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/Practitioner may use and disclose PHI for their own treatment, payment, and healthcare 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/Practitioner’s own TPO activities, but also for the TPO of another covered entity. Disclosure of PHI by one covered entity to another covered entity, or healthcare 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 healthcare provider for the payment activities of the recipient. Please note that “payment” is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of “services.”

2) 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/Practitioners to share PHI with Molina Healthcare for our healthcare operations activities, such as HEDIS and quality improvement.

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, unless otherwise permitted by Law.

Written Authorizations

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

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

1. **Notice of Privacy Practices**

Providers/Practitioners 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/Practitioner 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 healthcare Provider/Practitioner restrict its uses and disclosures of PHI. The Provider/Practitioner is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

Patients may request that a healthcare Provider/Practitioner communicate PHI by alternative means or at alternative locations. Providers/Practitioners must accommodate reasonable requests by the patient.

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

4. **Requests for Patient Access to PHI**

Patients have a right to access their own PHI within a Provider/Practitioner’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/Practitioner 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/Practitioner 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/Practitioner during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or healthcare operations or made prior to April 14, 2003.
HIPAA Security

Providers/Practitioners should implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of member PHI. Providers/Practitioners should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

In addition, medical identity theft is an emerging threat in the healthcare 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 healthcare 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 Healthcare.

HIPAA Transactions and Code Sets

Molina Healthcare requires the use of electronic transactions to streamline healthcare administrative activities. Molina Healthcare Providers/Practitioners must submit claims and other transactions to Molina Healthcare using electronic formats. Certain electronic transactions 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 Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers/Practitioners should refer to Molina Healthcare’s website at: [http://www.molinahealthcare.com](http://www.molinahealthcare.com) for additional information on HIPAA standard transactions.

National Provider Identifier

Provider/Practitioners must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider/Practitioners must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider/Practitioner. The Provider/Practitioner must report its NPI and any subparts to Molina Healthcare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to Molina Healthcare within 30 days of the change. Provider/Practitioners must use its NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to Molina Healthcare.

Additional Requirements for Delegated Providers/Practitioners
Providers/Practitioners that are delegated for claims and utilization management activities are the “business associates” of Molina Healthcare. Under HIPAA, Molina Healthcare must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers/Practitioners must agree to various contractual provisions required under HIPAA’s Privacy and Security Rules.

**Long-Term Care: Covered Services**

The community based and acute care services covered by Molina Healthcare of Florida through its Community Plus Program are listed below. All covered services must be authorized by Molina Healthcare of Florida prior to being rendered. Any changes to covered services will be communicated through updates to this Handbook, and/or contractual amendments.

**Community Based Services**

- Adult Companion Care Services
- Adult Day Health Care Services
- Assistive Care Services
- Assisted Living Services
- Attendant Care Services
- Behavioral Management Services
- Caregiver Training Service
- Case Coordination/Management Services
- Home Accessibility Adaptation
- Home Delivered Meals
- Homemaker Services
- Hospice Services
- Intermittent and Skilled Nursing (including Private Duty Nursing Services for members ages 18-20 years old)
- Medical Equipment and Supplies
- Medication Administration
- Medication Management
- Nursing Facility Services
- Nutritional Assessment/Risk Reduction Services
- Occupational Therapy Services
- Personal Care Services
- Personal Emergency Response Systems (PERS)
• Physical Therapy
• Respiratory Therapy Services
• Respite Care Services
• Speech Therapy Services
• Transportation Services

**Long-Term Care: Member Rights and Responsibilities**

Florida law requires that healthcare providers or healthcare facilities recognize member rights while they are receiving medical care and that members respect the healthcare provider’s or healthcare facility’s right to expect certain behavior on the part of its patients. Members may also request a copy of the full text of this law from their healthcare provider or healthcare facility. Under this law, members have the right to:

Members have the right:

• To be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

• To a prompt and reasonable response to questions and requests.

• To know who is providing medical services and who is responsible for his or her care.

• To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

• To know what rules and regulations apply to his or her conduct.

• To be given by health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

• To be able to take part in decisions about your health care. To have an open discussion about your medically necessary treatment options for your conditions, regardless of cost or benefit.

• To refuse any treatment, except as otherwise provided by law.

• To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

• If you are eligible for Medicare, to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

• To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
• To receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

• To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

• To treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

• To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

• To receive information about the Molina Healthcare Community Plus Program, its services, its practitioners and providers and members’ right and responsibilities.

• To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

• To request and receive a copy of his or her medical records, and request that they be amended or corrected.

• To be furnished health care services in accordance with federal and state regulations.

• To make recommendations about Molina Healthcare’s Community Plus member rights and responsibilities policies

• To voice complaints or appeals about the organization or the care it provides.

• To express grievance regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency listed below:

  Office of Civil Rights
  United States Department of Health and Human Services
  105 W. Adams, 16th Floor
  Chicago, Illinois 60603
  Phone: (312) 886-2359
  TTY: (312) 353-5693

  or

  Bureau of Civil Rights
  Florida Agency of Health Care Administration
  2727 Mahan Drive
  Tallahassee, FL 32308
  Phone: (888) 419-3456
Member Responsibilities

Members have the responsibility:

- For providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.
- For reporting unexpected changes in your condition to the health care provider.
- For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- To follow the care plan that you have agreed on with your provider.
- For keeping appointments and, when he or she is unable to do so for any reason, to notify the health care provider or healthcare facility.
- For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.
- To understand his or hers health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

Long-Term Care: Cultural Competency

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 or have speech or cognitive/intellectual impairments. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds 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](http://www.molinahealthcare.com), from your local Provider Services Representative and by calling Molina Provider Services at (855) 322-4076.

**Nondiscrimination of Healthcare 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 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 must not discriminate against enrollees based on their payment status and cannot refuse to serve Members because they receive assistance from a State Medicaid Program.

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](https://www.federalregister.gov/d/2016-11458)

**Molina Institute for Cultural Competency**

Molina is committed to reducing healthcare disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina founded the Molina Institute for Cultural Competency, which 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 training modules.

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

5. Written materials;

6. On-site cultural competency training delivered by Provider Services Representatives;

7. Access to enduring reference materials available through Health Plan representatives and the Molina website; and

8. 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, and aids and services that are congruent with cultural norms. Molina supports Members with disabilities, and assists 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](http://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 with 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 (Group 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 2010

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 (866) 472-4585. If Contact Center Representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a 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. 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 notification of his or her right to have a qualified interpreter at no cost.
Members with Hearing Impairment

Molina provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member & Provider Contact Center (M&PCC), 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 with hearing impairment. Requests should be made three 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.

Long-Term Care: Case Management

Role of Case Managers

Case management services facilitate member access to needed medical, social, and educational services. Each Molina Community Plus Program member will be assigned to a case manager that will coordinate and ensure delivery of medical care and services available under the program.

Molina Healthcare of Florida Community Plus case managers will:

- Develop individual plans of care that address identified problems, needs and conditions
- Coordinate the delivery of covered services
- Issue authorizations for covered services
- Coordinate and integrate acute and long term care services
- Collaborate with member’s physicians and other providers to arrange for needed care
- Provide frequent communication with members to evaluate and discuss needed care
- Promote independent living and quality of life
Case managers will routinely assess member needs and perform interventions as necessary. Interventions may be performed by:

- Face-to face home visits with member and family/caregiver(s)
- Telephonic follow up with member and family/caregiver(s)
- Providing educational materials
- Communicating with service providers

Case managers are responsible for determining the appropriateness of all requests for authorization and changes to existing authorizations. Authorizations for new or changed services are initiated when one of the following conditions apply:

- Services are necessary to address health and social service needs of the member
- Member fails to respond to current care plan
- Services are furnished in a manner not primarily intended for the convenience of the member or member’s caregiver(s)

**Obtaining Authorization**

All covered services must be authorized by Molina Healthcare of Florida Community Plus Program case managers. Providers should contact the member’s case manager for authorization of services, or submit a Prior Authorization Request Form via fax. The approval of services and scope of such services will be communicated in writing to the requesting provider.

**Case Management Phone: (855) 322-4076**

**Case Management Fax: (877) 902-6825**

Services that are covered by Medicare should be accessed through the Medicare Fee-For-Service program or through the member’s Medicare Advantage plan.

**Long-Term Care: Medical Necessity Standards**

Medically Necessary or Medical Necessity is defined as services that include medical or allied care, goods or services furnished or ordered to meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs
- Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
• Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide

• Be furnished in a manner not primarily intended for the convenience of the Member the Member’s caretaker or the provider

Medically Necessary services furnished in a Hospital on an inpatient basis, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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.

**Long-Term Care: Coordination of Care**

Molina Healthcare provides individualized case management services for members with chronic, complex, high-risk and catastrophic conditions. Case managers, in conjunction with Utilization Management and Disease Management will work with providers, members, member representatives to coordinate care, provide referral assistance and other support for at risk members. Case Managers also identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care; ensuring efforts are efficient and non-duplicative.

**Hospital Admissions**

Providers must immediately notify a Molina Healthcare of Florida Community Plus case manager when a member requires hospitalization or has been admitted to a hospital, Assisted Living Facility (ALF), or Nursing Home (NH). Notification must be given within 24 hours of knowledge of the admission.

Notification of admission must include clinical information needed to determine the appropriateness of the admission

The case manager will proactively assist the member with discharge planning needs prior to returning to the community by collaborating with family/caregiver(s), inpatient discharge planner and the facility.

Inpatient hospitalizations are covered by Medicare fee-for-service program or the member’s Medicare Advantage plan. For additional information regarding hospital admissions and coverage, please contact Case Management at (855) 322-4076.

**24-Hour Telephonic Coverage**

The network providers listed below are required to have 24-hour telephonic coverage:
• Assisted Living Facilities
• Emergency Response Systems
• Nursing Homes

Emergency Services

Medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists. If such a condition exists, emergency services and care include the care or treatment necessary to relieve or eliminate the emergency medical condition within the service capability of the facility.

Molina Healthcare provides Utilization Management during business hours and a (24) hour Nurse Triage option on the main telephone line for post business hours. Services rendered as an emergency medical situation, do not require an authorization.

In the event of an emergency, providers should call 911 and direct the member to the nearest emergency room for assistance.

Long-Term Care: Quality Assurance

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

Quality Assurance Program Goals

• Design and maintain programs that improve the care and service outcomes within identified Member populations, ensuring the relevancy through understanding of the health plan's demographics and epidemiological data
• Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of care, Member safety and service
• Improve the quality, appropriateness, availability, accessibility, coordination and continuity of the health care and service provided to Members
• Through ongoing and systematic monitoring, interventions and evaluation improve Molina Healthcare structure, process, and outcomes
• Using feedback from stakeholders, improve reporting methods to make information available, relevant and timely
• Use a multidisciplinary committee structure to facilitate the achievement of quality assurance goals, improve organizational communication and ensure participation of contracted community providers in clinical aspects of programs and services
• Facilitate organizational efforts to achieve and maintain regulatory compliance and to continually review practices to ensure compliance with standards and contractual requirements

The QAP assists in achieving these goals through an evaluation process of both clinical and service outcomes measuring the effectiveness of internal processes and active improvement interventions. The QAP outlines several functional aspects of the QAP that contributes to a high level of clinical and service quality.

• Health Management Programs; Breathe with Ease for Asthma, Healthy Living with Diabetes,
• Preventive Care and Clinical Practice Guidelines
• Measurement of Clinical and Service Quality; HEDIS, CAHPS® (Consumer Assessment of Health Plan Survey), Provider Satisfaction Survey, and Key Quality Metrics

Preventive Care and Clinical Practice Guidelines

This section provides an overview of adopted clinical practice guidelines for Molina Healthcare. All clinical practice guidelines are based on scientific evidence, review of medical literature, or appropriate established authority as cited. All recommendations are based on published consensus guidelines and do not favor any treatment based solely on cost consideration.

The recommendations for care are suggested as guidelines for making clinical decisions. Providers and their patients must work together to develop individual treatment plans tailored to the specific needs and circumstances of each patient.

Molina Healthcare has standard clinical practice guidelines in the following areas:

• Depression – Adopted from the American Psychiatric Association
• ADHD – Adopted from the American Psychiatric Association
• Asthma – Adopted from the new NHLBI Asthma Guidelines by the Florida State Medical Association, in conjunction with community asthma provider
• Cardiovascular – ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in Adults, ATPIII Guidelines for High Blood Cholesterol, Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) and the AHA/ACC Guidelines for Preventing Heart Attack and Death in Patients With Atherosclerotic Cardiovascular Disease: 2001 Update
• COPD – The Global Initiative for Chronic Obstructive Lung Disease guidelines for COPD care
• Diabetes Mellitus – Adopted from the American Diabetes Association Clinical Practice Guidelines
• Preventive Care and Pregnancy Guidelines – Based on recommendations from the U.S. Preventive Services Task Force

On the Molina Healthcare website you will also find information regarding:

• Preventive Screening, Immunization and Counseling Guidelines
• Immunization Schedules
• Educational tools for patients
• Educational tools for your office

Guidelines are reviewed annually and updated as appropriate. If you would like a printed copy of the guidelines, you may request it by calling our Health Education Line at (855) 322-4076.

**Measurement of Clinical and Service Quality:**

• Health Employer Data Information Set (HEDIS)
• Consumer Assessment of Health Plans Survey (CAHPS®)
• Provider Satisfaction Survey
• Effectiveness of Quality Assurance Initiatives

**HEDIS**

Molina Healthcare utilizes NCQA HEDIS as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS is conducted annually 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, appropriate use of asthma medications, and prenatal and postpartum care.

HEDIS results are used in a variety of ways. They are the measurement standard for many of Molina Healthcare’s Community Plus clinical quality assurance 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. These activities include Molina Healthcare’s diabetic and asthma health management programs, childhood and adolescent well-child and immunization program, and prenatal and postpartum care programs.

Selected HEDIS results are provided to (HRSA) as part of our contract Health plans also submits results directly to NCQA, consistent with the original intent of HEDIS – to provide health care purchasers data with which to make informed decisions. The data is also used by NCQA to
establish health plan performance benchmarks and are an integral part of the NCQA health plan accreditation process.

Your office may be requested to submit documentation from medical files as part of the HEDIS data collection process.

**CAHPS®**

CAHPS® is the tool used by NCQA to summarize member satisfaction with health care, including Providers and health plans. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Providers Communicate, Courteous and Helpful Office Staff, and Customer Service. The CAHPS® survey is administered annually in the spring to randomly selected adult Members. In even-numbered years, HRSA also sponsors a Medicaid CAHPS® survey specific to the care provided to pediatric Members.

CAHPS® survey results are used in much the same way as HEDIS results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Molina Healthcare’s quality assurance activities and are used by external agencies and health care purchasers to help ascertain the quality of services being delivered.

**Provider Satisfaction Survey**

Recognizing that HEDIS and CAHPS® both focus on member experience with health care providers and health plans, Molina Healthcare conducts a Provider Satisfaction Survey in the fall of each year. The results from this survey are very important to Molina Healthcare, as this is one of the primary methods we use to identify improvement areas pertaining to the Provider network. The survey results have helped establish improvement activities relating to Molina Healthcare’s specialty network, inter-provider communications, and pharmacy authorizations. This survey is conducted by an external vendor and is sent to a statistically valid, random sampling of Providers each year. If your office is selected to participate, please take a few minutes to complete it and send it back.

**Effectiveness of Quality Assurance Initiatives**

Molina Healthcare 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 a best practice. The Clinical Quality Assurance Committee (CQAC), which includes Members from the Provider network, evaluates clinical metrics on an ongoing basis. Results of these measurements guide activities for the successive periods.

- Clinical Metrics include but are not limited to the following:
  - Clinical Practice Guideline Compliance measurement
- HEDIS measures for asthma, diabetes, and chlamydia screening
- Use of short-acting beta-agonists for Members with asthma
- Follow-up Chlamydia testing after positive result and treatment
- Use of antibiotics for upper respiratory disease

- Effectiveness of interventions in breathe with ease, Healthy Living with Diabetes, Heart Healthy Living, Chronic Obstruct Pulmonary Disease (COPD) programs:
  - Post-hospital follow-up rate with PCP or Specialist
  - Inpatient and emergency department utilization
  - Readmission after primary diagnosis of asthma, diabetes, COPD or a cardiovascular condition
  - Key clinical metrics including but not limited to: annual hemoglobin A1C and eye exams for diabetics and beta-blocker use and cholesterol testing after an acute cardiac event

- Service Improvement Metrics include but are not limited to:
  - UM authorization turnaround times
  - Pharmacy authorization turnaround times
  - Member Services response time
  - Satisfaction with Molina Healthcare specialty network (as measured through CAHPS® and Provider Satisfaction Survey)

**Preventive Health, Health Education and Incentive Programs**

Molina Healthcare integrates Health Education and Health Management Program goals with HEDIS Effectiveness of Care and Access rate improvement efforts. Member incentives continue to be successfully utilized to encourage Members to access important care and services.

If you have any questions regarding these programs, please call our Health Education Line at (855) 322-4076.

**Long-Term Care: Quality Assurance Committee**

Molina Healthcare of Florida maintains a quality assurance committee that is a separate mechanism for addressing the quality assurance concerns of eligible frail members. The responsibilities of the quality assurance committee are as follows:

- Oversee quality of life indicators such as, but not limited to, the degree of personal autonomy, provision of services and supports to assist people in exercising medical and social choices, self-direction of care and maximum use of natural support networks.
• Review grievances and appeals identified through the Contractor’s policies and procedures and through external oversight.

• Review case records of all fair hearings and document internal complaint/grievance steps involved in the fair hearing, as well as other pertinent information for the enrollee.

• Review quality assurance policies, standards, and written procedures to ensure that the needs of the enrollees are adequately addressed.

• Review utilization of services with adverse or unexpected outcomes for enrollees.

• Develop and periodically review written guidelines, procedures and protocols related to areas of concern in the care of the frail elderly.

• Develop an ethics committee to review ethical questions such as end-of-life decisions and advance directives.

• Develop a system of peer review by physicians and other service providers.

Quality Enhancement

Molina Healthcare offers Quality Enhancement programs to its members. Members may access these programs by communicating with their Case Manager.

• Fall prevention, and home safety.

• Advance directives and end of life concerns.

• Ensure that Case Managers and providers monitor for domestic violence and elder abuse and exploitation, and offer referral services to applicable community agencies.

Credentialing and Recredentialing

The Molina Healthcare Credentialing Department is responsible for performing, tracking or monitoring all aspects of the credentialing and re-credentialing process under the purview of the Quality Management Department for providers joining or participating in the Molina Healthcare network. The credentialing process is designed to meet the State of Florida Requirements and NCQA Standards. In accordance with those standards, Molina Healthcare members will not be referred and/or assigned to a provider until the credentialing process has been completed on your submitted practitioner application. Molina Healthcare accepts Council for Affordable Quality Healthcare’s (CAQH) credentialing information or our standard practitioner application that contains the State of Florida specific profile elements. Molina Healthcare can contract with Medical Groups/ IPAs who have the ability to perform the credentialing functions, per NCQA credentialing standards and guidelines allowing us to delegate credentialing privileges.

Evaluation
As an applicant being credentialed or re-credentialed, you are required to submit adequate information that will allow Molina Healthcare to perform a proper evaluation of your:

- Experience
- Background
- Education and training
- Demonstrated ability to perform as a provider without limitation, including physical and mental health status as allowed by law

Any provider meeting the definition of a “direct service provider” must complete a Level II criminal history background screening to determine whether the provider, or any employees or volunteers of the provider have disqualifying offenses as provided for in s. 430.0402 F.S. and s. 435.04, F.S. Direct service providers are persons eighteen (18) years of age or older who, pursuant to a program to provide services to the elderly or disabled, has direct, face-to-face contact with a client while providing services to the client and has access to the client’s living areas, funds, personal property, or personal identification information as defined in s. 817.568, F.S. The term includes coordinators, managers, and supervisors of residential facilities and volunteers (see s. 430.0402(1)(b), F.S.)

Any provider, or any employees or volunteers of the provider who has a disqualifying offense is prohibited from contracting with Molina Healthcare of Florida,

Should your application be incomplete in any way, you and/or your Medical Group/IPA will receive a request from Molina Healthcare to provide the needed information within a specified timeline.

**Professional Review Committee (PRC)**

All Molina Healthcare providers must be credentialed and approved by the Medical Director and / or PRC in order for their contract to become effective. The Molina Healthcare PRC participants are made up of your professional peers. As soon as your credentials file contains all of the necessary documentation, verifications, medical record and site review findings, it will be submitted for review and/or approval by the PRC. If the PRC determines further information is necessary to evaluate your application, the Credentialing Department will request such information on behalf of the PRC. The PRC may, in its sole discretion, request that you appear for an interview. The Governing Board of Molina Healthcare has delegated the authority to approve and deny applicants to the PRC. The PRC is required to meet no less than quarterly, but generally meets on a monthly basis, to facilitate timely processing of Provider applicant files.

**Verification and Approval**

The Credentialing Department will verify the following provider information that includes but is not limited to:

- Current, unrestricted license to practice
• Current, valid Drug Enforcement Agency (DEA) certificate
• Education and training
• Work history from the time of medical school graduation
• Board Certification
• Clinical admitting hospital privileges in good standing
• Current, adequate malpractice liability coverage
• All professional liability claims history
• References (if applicable)
• Appropriate (24) hour coverage
• Identify any disciplinary actions and/or sanctions
• Query the National Practitioner Data Bank (NPDB)

Re-credentialing

Once a provider or facility is approved for participation in Molina Healthcare’s network, re-credentialing is performed every three years. You will receive a re-credentialing application approximately six months before your credentialing period is to expire. The format used is that of a “profile” and only information that may have changed since the last credentialing will be requested. We request that you verify the information on the profile sheet and return it to us within the specified time frame. Failure to return the information will result in administrative termination from the Molina Healthcare network as a non-compliant provider.

Information that is reviewed as part of the re-credentialing process includes:

• Verifying that our providers continue to meet the basic qualifications
• Information from reported quality performance issues, such as utilization data, member satisfaction surveys and customer service reports

Should your DEA, medical license and/or liability insurance coverage expire at some time prior to your next re-credentialing date, you and/or your Medical Group/IPA will receive a request for updated information for your credentials file. Failure to provide this information within the specified time will result in automatic suspension and/or termination from the Molina Healthcare network.

Provider’s Right to Review

Providers have the right to review their credentials file at any time. The provider must notify the Molina Healthcare Credentialing Department in writing and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Molina Healthcare Medical Director and the QI/Credentialing 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 are the application, the license and 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. NPDB, Department of Health/Medical Quality Assurance Commission), and verification of hospital privileges letters.

**Provider’s Right to Notification and Correction of Erroneous Information**

Molina Healthcare shall notify the provider immediately, in writing, in the event that Molina Healthcare receives information that conflicts with information given by the provider. Examples include, but are not limited to actions on a license; malpractice claims history or board certification decisions. The notification shall detail the information in question.

The Provider must submit a written response to:

Molina Healthcare of Florida, Inc.
Attention: Credentialing Department
8300 NW 33rd Street
Suite 400
Miami, FL 33122

This response must be sent by the provider within thirty (30) calendar days of receiving notification from Molina Healthcare. The notification shall detail the information in question. The provider must explain the discrepancy and may correct any erroneous information or provide any proof that may be available. If the provider does not respond within thirty (30) calendar days, application processing will be discontinued and network participation will be denied.

Upon receipt of notification from the provider, Molina Healthcare will 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 the credentials file. If the primary source information remains inconsistent with providers’ notification, the Credentialing Department will notify the provider. The provider may then provide proof of correction by the primary source body to Molina Healthcare’s Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

**Providers Right to be informed of Application Status:**

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Providers have a right, upon request, to be informed of the status of their application. Providers applying for initial participation are sent a letter when their application is received by Molina Healthcare and are notified of their right to be informed of the status of their application in this letter. Providers are also notified of their right in the Provider Manual sent to them at the time of initial contracting.

Providers can request to be informed of the status of their application by telephone, mail or email. Molina Healthcare will respond to the request within two (2) working days. Molina Healthcare may share with the provider the status of the application in the credentialing process. Molina Healthcare does not share with, or allow a provider to review references or recommendations, or other information that is peer-review protected.

Pursuant to section 1128 of the SSA, Molina Healthcare and its subcontractors may not subcontract with an excluded provider/person. Molina Healthcare and its subcontractors shall terminate subcontracts immediately when Molina Healthcare and its subcontractors become aware of such excluded provider/person or when Molina Healthcare and its subcontractors receive notice from CMS. Molina Healthcare 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 Healthcare and its subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its subcontractors shall attach a written explanation to this Agreement.

Corrective Action, Fair Hearing Plan, and Reporting to the Florida Division of Medical Quality Assurance, Department of Health (Licensing Board) and the NPDB:

Providers have the procedural right to appeal in the event that PRC recommendations and actions result in filing a report to the Florida Division of Medical Quality Assurance, Department of Health and the NPDB. The appeal right, Fair Hearing process, and the requirement to report to the Florida Division of Medical Quality Assurance, Department of Health and NPDB are described in Molina Healthcare’s Provider Discipline and Fair Hearing Plan.

Long-Term Care: Provider Notifications

Providers will immediately notify Molina Healthcare of Florida, if any of the following events occur:

- Provider’s business license to practice in any state is suspended, surrendered, revoked, terminated, or subject to terms of probation or other restrictions.
- Provider has any malpractice claim asserted against it by a Molina Healthcare of Florida Community Plus member, or any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of provider pursuant to a judgment rendered upon such a claim
- Provider is the subject of any criminal investigation or proceeding
• Provider is convicted for crimes involving moral turpitude or felonies
• Provider is named in any civil claim that may jeopardize Provider’s financial soundness
• There is a change in provider’s business address, telephone number, ownership, or Tax Identification Number
• Provider’s professional or general liability insurance is reduced or canceled
• Provider becomes incapacitated such that the incapacity may interfere with member care for 24 hours
• Any material change or addition to the information submitted as part of provider’s application for participation with Molina Healthcare of Florida Community Plus
• Any other act, event or occurrence which materially affects provider’s ability to carry out its duties under the Provider Services Agreement

**Long Term Care: Provider Compliance – Community Outreach**

Molina Healthcare of Florida’s Community Outreach team may furnish community outreach materials at health fairs and/or public events after written notification to the Agency. The main purpose of such materials shall be to provide community outreach and not be for the sole purpose of marketing.

Molina Healthcare shall ensure, through provider education, outreach and monitoring that its providers are aware of and comply with the following:

• Providers are permitted to make available and/or distribute Managed Care Plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates. The Agency does not expect providers to proactively contact all Managed Care Plans; rather, if a provider agrees to make available and/or distribute Managed Care Plan marketing materials it should do so knowing it must accept future requests from other Managed Care Plans with which it participates. Providers are also permitted to display posters or other materials in common areas such as the provider’s waiting room. Additionally, long-term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.

Molina Healthcare shall ensure, through provider education, outreach and monitoring that its providers are aware of and comply with the following:

• To the extent that a provider can assist a potential enrollee in an objective assessment of his/her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with potential enrollees should a potential enrollee seek advice. However, the provider shall remain neutral when assisting with enrollment
decisions.

Contracted Providers may not:

(a) Offer marketing/appointment forms.

(b) Make phone calls or direct, urge or attempt to persuade potential enrollees to enroll in the Managed Care Plan based on financial or any other interests of the provider.

(c) Mail marketing materials on behalf of the Managed Care Plan.

(d) Offer anything of value to induce potential enrollees to select them as their provider.

(e) Offer inducements to persuade potential enrollees to enroll in the Managed Care Plan.

(f) Conduct health screening as a marketing activity.

(g) Accept compensation directly or indirectly from the Managed Care Plan for marketing activities.

(h) Distribute marketing materials within an exam room setting.

(i) Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan.

Contracted Providers may:

(a) Provide the names of the Managed Care Plans with which they participate.

(b) Make available and/or distribute Managed Care Plan marketing materials outside of an exam room.

(c) Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office.

(d) Share information with patients from the Agency’s website or CMS’ website.

Provider Affiliation Information

(a) Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).

(b) Providers may make new affiliation announcements within the first thirty (30) days of the new provider contract.
(c) Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email, or phone.

(d) Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.

(e) Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.

Long-Term Care: Grievances and Appeals

Molina Healthcare Community Plus members or members’ personal representatives have the right to file grievances and submit appeals through a formal process. If a member is unhappy with the service from Molina Healthcare Community Plus or any of its network providers, they may file a complaint, grievance, or appeal by contacting Member Services toll-free at:

(866) 472-4585 between the hours of 8:30 a.m. to 5:00 p.m., Monday through Friday.

A complaint is the informal level of the grievance process. Complaints are to be resolved by the end of the next business day. If not resolved within that time frame they are moved to the next level of the grievance process within (24) hours.

Members may send the grievance or appeal in writing to:

Molina Healthcare Community Plus
Attn: Grievance and Appeals Department
PO Box 521838
Miami, FL 33152-1838

Members may also send their written grievance or appeal via fax to: (877) 508-5748 or submit via email at: MFLGrievanceandAppeals@MolinaHealthcare.com

Members are notified of their grievance and appeal rights through various general communications including but not limited to the Member Handbook-Evidence of Coverage and Disclosure, member newsletters and on our web site www.molinahealthcare.com.

Members may identify an individual, including an attorney or provider, to serve as a personal representative to act on their behalf at any stage of the grievance or appeals process. If under applicable law, a person has authority to act on behalf of a member in making decisions related to health care or is a legal representative of the member, Molina Healthcare of Florida Community Plus will treat such person as a personal representative.

If the Member/Provider registers an informal complaint, Molina Healthcare will attempt to resolve the complaint within 24 hours. If the complaint cannot be resolved, it will be treated as a formal grievance. A member may file a grievance orally or in writing at any time.
A member, authorized representative, or legal representative of the estate may file a plan appeal orally or in writing within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination.

Members are given reasonable assistance in completing forms and taking other procedural steps, including translation services for members with limited English proficiency or other limitations, i.e., hearing impaired, requiring communication support.

Members will continue any and all benefits while in the grievance and appeals process if their appeal is filed timely and is related to termination, suspension, or reduction of a previously authorized course of treatment, the services were ordered by a network provider, the authorization period has not expired and the member has requested an extension of benefits. To be considered timely, appeals must be filed to Molina Healthcare of Florida within 10 days of the Notice of Adverse Benefit Determination or on or before the intended date of the proposed action. In the alternative, the member may request a Medicaid Fair Hearing with Continuation of Benefits within ten (10) days of the Notice of Plan Appeal Resolution.

Benefits will be extended until the member withdraws the appeal; ten (10) days pass from the date of the Notice of Adverse Benefit Determination; a hearing officer issues a hearing decision adverse to the member; or the time period or service limits of a previously authorized service have been met.

All grievances and appeals whether oral or in writing, are acknowledged in writing within 5 business days from receipt. Any issues related to a clinical denial and/or appeal of a coverage decision, is referred to the Utilization Management Department to review the medical necessity aspects of the request.

A person not involved in the previous decision-making process reviews the grievance or appeal to determine the resolution. In appeals involving denial of clinical services, health care professionals with appropriate expertise conduct the review. A Medical Director of same or similar specialty who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination will review the appeal and make the determination.

All grievance and appeal requests concerning admissions, continued stay, immediate care issues, or other services for members who have received emergency services but have not been discharged from a facility are granted an Expedited Review. Expedited Reviews are completed as promptly as the medical condition requires, but no later than seventy-two (72) hours after the request. If the grievance or appeal does not meet criteria for expedited review, it will be processed within the required timeframes for standard grievances and appeals.

Any grievance or appeal with Potential Quality of Clinical Care (PQOC) and/or Critical Incidents issues is referred to the Quality Improvement Department for further investigation and handling. Additionally, any identified issue related to the Privacy and Confidentiality of Protected Health Information (PHI) is referred to the Privacy Officer.
All grievance decisions are made within state established time frames not to exceed ninety (90) calendar days from the day the initial grievance is received. However, the grievance process time-frame may be extended up to fourteen (14) calendar days if the member voluntarily agrees to an extension. All appeal decisions are made within (30) calendar days from the day the appeal is received. However, the appeal process time-frame may be extended up to (14) calendar days if the Member voluntarily agrees to an extension.

All aspects of the review process are documented and tracked in Molina Community Plus core data maintenance application and Grievance and Appeal database.

A member who has completed the Managed Care Plan’s appeal process may file for a Medicaid Fair Hearing within one hundred twenty (120) calendar days of receipt of the notice of plan appeal resolution. To request a Fair Hearing, Members/Member representative, should contact:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906

Phone: (877) 254-1055
Fax: (239) 338-2642
MedicaidHearingUnit@ahca.myflorida.com

Members also have the right to request an external independent review with the Subscriber Assistance Program (SAP), after they have exhausted their appeal rights with Molina Healthcare of Florida. Members that resort to a Medicaid Fair Hearing may not also request review by the Subscriber Assistance Program (SAP).

To request a review through the Subscriber Assistance Program (SAP), contact the Agency for Healthcare Administration at the address and/or telephone number listed below:

Agency for Health Care Administration
Subscriber Assistance Program
Building 3, MS #45
2727 Mahan Drive
Tallahassee, Florida 32308
(850) 412-4502
(888) 419-3456 (toll-free)

Expedited Appeals

An appeal will be expedited in response to the clinical urgency of the situation; i.e., when a delay would jeopardize a member’s life or materially jeopardize a member’s health. A request to expedite may come from the member, a provider, or when Molina Community Plus feels it prudent to do so. An expedited appeal will be acted on quickly and a decision made within seventy-two (72) hours.
Long Term Care: Provider Complaint Process

Provider Disputes and Appeals

Molina Healthcare is committed to the timely resolution of all provider complaints. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. A written request by a provider received at Molina Healthcare for review of an action is considered a Provider Appeal.

Provider Claims Disputes

Providers disputing a Claim previously adjudicated must request such action within one (1) year 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 Provider Dispute/Appeal Form 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, secure email or mail. Claims Disputes/Reconsideration requested via the Provider Dispute/Appeal Form may be sent to the following address:

Molina Healthcare of Florida, Inc.
Attention: Grievance & Appeals Department
PO Box 527450
Miami, Florida 33152-7450

Submitted via fax:
(877) 553-6504

Secure email:
MFL_ProviderAppeals@MolinaHealthcare.com

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.

For claims related issues, the Provider will be notified of Molina’s decision in writing within sixty (60) days of receipt of the Claims Dispute/Adjustment request.

Provider Complaints Not Related to Claims
To file a Provider Complaint not related to claims, providers may contact Member Services at (866) 472-4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida, Inc.  
Attention: Grievance & Appeals Department  
PO Box 527450  
Miami, Florida 33152-7450

Submitted via fax:  
(877) 553-6504

Secure email:  
MFL_ProviderAppeals@MolinaHealthcare.com

Provider Complaints must be received within one (1) year of the date of payment or denial of the claim. All Provider Complaints will be reviewed confidentially by the Grievance and Appeals Department.

For non-claims related issues, the outcome will be communicated in writing within ninety (90) days of receipt of the Provider Dispute.

**Long-Term Care: Risk Management Program**

Molina Healthcare of Florida’s Risk Management Program strives to provide quality care and service to our members. Risk Management is an integrated, company-wide program for the prevention, monitoring, and control of areas of potential liability exposure. It is the intent of Molina Healthcare of Florida, via the Risk Management Program to enhance the safety of patients, visitors, and employees; and minimize the financial loss to Molina Healthcare of Florida through risk detection, evaluation, and prevention.

Molina Healthcare of Florida maintains a risk management process that is designed to assure that network providers possess the credentials, including training and experience, to provide members the level of quality of care consistent with the mission of Molina Healthcare of Florida.

The program focuses on identification and prevention of risk exposures within the organization that could:

- Cause injury to patients, visitors, and employees  
- Jeopardize the safety and security of the environment  
- Result in costly claims and lawsuits with subsequent financial loss to the organization

The Risk Management Program is administered by the Quality Improvement Department. The Chief Medical Director and Director of Quality Improvement are responsible for the
implementation and operation of the Risk Management Program which reports quarterly to the Quality Assurance Committee and to the Molina Healthcare of Florida Board of Directors.

**Risk Management Program Components**

- Governing Body accountable for the Risk Management Program administered through the Quality Assurance Committee

- Administrative Procedures providing for the systematic review and reporting of incidents, member grievances, identification of trends, implementation of corrective action and risk management prevention education and training

- Member Grievance process that promotes the analysis of member grievances related to care and quality of medical services

- Potential Quality of Care (PQOC) investigation and analysis of the frequency and causes of adverse events causing injury to members and a Critical Incident Reporting system that employs measures to minimize the risk of injuries and adverse incidents

- Education and training programs, companywide or department-specific, to uphold the objectives of the Risk Management Program and as required address corrective action or trend identification

**Long-Term Care: Medical Records Standards**

Molina Healthcare providers are 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 and facilitated to Molina Healthcare to review the quality and appropriateness of the services rendered as necessary.

Medical records are to be stored in a secure manner that permits easy retrieval and maintained for a period not less than 6 years for the long term care contract, or retained further if the records are under review or audit. 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.
Providers are also required to document all directly provided services, charges, dates and any other information relevant to the services rendered to members. The provider will make available the duplication and transfer of any records or documents at no additional cost to the health plan or Agency.

**Medical Record Retention**

Medical records must be maintained for a period not less than ten (10) years from the close of the Provider Services Agreement, and retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by Molina Healthcare if the Provider Services Agreement is continuous.

**Long-Term Care: Claims & Reimbursement**

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 X12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 51062. For Members assigned to a delegated medical group/IPA that processes its own Claims, please verify the Claim Submission instructions on the Member’s Molina ID card.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

**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.

**Electronic Claims Submission**

Molina requires 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 **51062**

**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.

**Coordination of Benefits and Third Party Liability**

**COB**

Medicaid is the payer of last resort. Private and governmental carriers must be billed prior to billing Molina Healthcare or medical groups/IPAs. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance, benefits or Covered Services other than from Molina Healthcare or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Molina Healthcare of said entitlement.

In the event that coordination of benefits occurs, Provider shall be compensated based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOBs and other required documents, by utilizing Molina’s Provider Portal.

**Third Party Liability**

Molina Healthcare is the payer of last resort and will make every effort to determine the appropriate Third Party payer for services rendered. Molina Healthcare may deny Claims when Third Party has been established and will process Claims for Covered Services when probable Third Party Liability (TPL) has not been established or third party benefits are not available to pay a Claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL collections on behalf of Members for audit and review.

**Timely Filing**

F.S. 641.3155 requires that providers submit all claims within six (6) months of the date of service. Network providers must make every effort to submit claims for payment in a timely manner, and within the statutory requirement.

If Molina Healthcare of Florida Community Plus is not the primary payer under coordination of benefits (COB), providers must submit claims for payment to Molina Healthcare of Florida Community Plus within ninety (90) days after the final determination by the primary payer.
Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted to Molina Healthcare of Florida Community Plus within these timelines will not be eligible for payment, and provider thereby waives any right to payment.

**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 no later than seven (7) days following the date on which the Molina adjudicates the claims 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

**Patient Responsibility**

**What is Patient Responsibility?**

Patient Responsibility is the cost of Medicaid Long-Term Care (LTC) services not paid for by the Medicaid program, for which the member is responsible. Patient responsibility is the amount member must contribute toward the cost of their care. The amount of patient responsibility is determined by the Department of Children & Families (DCF) and is based on income and choice of residence.
Medicaid must reduce payments for Home and Community-Based Services (HCBS) provided under the Statewide Medicaid Managed Care (SMMC) LTC waiver, by the amount of the member’s patient responsibility, in compliance with Title 42, Section 435.726, Code of Federal Regulations; and Section 2404 of the Affordable Care Act. This includes residents in Assisted Living Facilities (ALFs), Nursing Facilities (SNFs), Hospices, and Adult-Family Care Homes (AFCHs).

DCF calculates and determines member patient responsibility. Members are responsible for the patient responsibility determined by DCF when residing in a participating residential facility. **Providers are responsible for collecting patient responsibility and room and board for Molina members.** Molina will reduce payments made to SNF’s, Hospices, ALF’s and AFCH’s by the amount of patient responsibility determined by DCF.

**Submitting Documentation to DCF**

The facility or member must provide DCF with documentation of the amount of the facility’s basic room and board charges per month. The amount of the facility’s basic room and board charges covers three (3) meals per day and a semi-private room. The amount of the facility’s basic room and board charges does not cover any goods and services beyond three (3) meals per day and a semi-private room.

The member may submit the facility’s documentation to DCF by uploading files online to their MyACCESS Account or, they, or the facility may submit documentation to DCF by either:

Faxing the documentation to: (866)-886-4342 or mailing the documentation to:

**ACCESS Central Mail Center**
**PO Box 1770**
**Ocala, FL 34478-1770**

**Uncovered Medical Expense Deduction**

An Uncovered Medical Expense Deduction (UMED) may occur when the Molina member incurs a charge for a medically necessary service that is not covered by a third party payer, Medicare, MMA, or LTC. Examples of qualified UMEDs are: a premium, deductible, or coinsurance charge for health insurance coverage or medical expenses that are approved by DCF.

DCF may change the monthly amount of patient responsibility and determine to increase the amount of the member’s patient responsibility due to an increase in the member’s income or decrease the amount of patient responsibility due to a DCF approved UMED. DCF will notify members when there is a change in the monthly amount of patient responsibility by mailing a Notice of Case Action (NOCA) to the member.

Members must notify DCF within ten (10) days of receiving a bill/receipt of what medical expenses (paid or unpaid) they have to pay. The member may submit the proof of medical expenses to DCF by uploading files online to their MyACCESS Account, by faxing the documentation to: (866)-886-4342 or mailing the documentation to:
Verifying Member Patient Responsibility

Providers may view member patient responsibility information via the ‘DCF Provider View’ option in the Florida Medicaid Secure Provider Web Portal found at: https://sso.flmmis.com/adfs/ls/?wa=wsignin1.0&wtrealm=https%3a%2f%2ffsso2.flmmis.com%2fadfs%2fs%2fid&wctx=d19e0a5d-f160-413b-936d-7f68bde377d4&wct=2016-10-10T18%3a52%3a50Z&whr=https%3a%2f%2ffsso.flmmis.com%2fadfs%2fs%2fid

Providers may also contact DCF if there are any questions about the information found on the DCF Provider Portal or if they are unable to obtain needed information by contacting the DCF Customer Call Center at: (866)-762-2237.

Long-Term Care: Fraud, Waste & Abuse

Molina Healthcare of Florida maintains a comprehensive Fraud, Waste, and Abuse program. The program is held accountable for the special investigative process in accordance with federal and state statutes and regulations. Molina Healthcare of Florida is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, the Compliance department maintains a comprehensive plan, which addresses how Molina Healthcare of Florida will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. Molina’s Special Investigation Unit supports Compliance in its efforts to deter and prevent fraud, waste, and abuse by conducting investigations to identify and report findings to the appropriate regulatory and/or law enforcement agencies. The program also addresses fraud prevention and the education of appropriate employees, vendors, providers and associates doing business with Molina Healthcare of Florida.

Mission Statement

Molina Healthcare of Florida 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 Healthcare of Florida 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, including the Medicare and Medicaid programs. 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.

Florida False Claims Act

Florida has also enacted a state False Claims Act (F.S. Title VI, §§ 68.081-68.089) in 2007 to allow for the recovery of state funds in addition to federal funds for false claims. The provisions of the Florida False Claims Act (FFCA) are similar, but not identical to, the provisions of the federal FCA. The FFCA provides for civil penalties of not less than $5,500 and not more than $11,000 per violation, for three times the damages to state government due to false claims, and for recovery of attorney’s fees and court costs.

Deficit Reduction Act

On February 8, 2006, the Deficit Reduction Act (“DRA”) was signed into law, which became effective on January 1, 2007. The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

Health care entities like Molina Healthcare of Florida who receive or pay out at least $5 million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Molina Healthcare of Florida, providers and their staff have the same obligation to report any actual or suspected violation of Medicare/Medicaid funds either by fraud, waste or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;
- How providers will detect and prevent fraud, waste, and abuse;
- Employee protection rights as a whistleblowers.

Whistleblower Protection
The Federal False Claims Act, the Florida False Claims Act, and the Medicaid False Claims Act have Qui Tam language commonly referred to as “whistleblower” provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

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

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

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

Definitions

**Fraud:**

“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. For example: the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome of poor or inefficient billing methods (e.g. coding) causes unnecessary costs to the Medicaid program.

**Abuse:**

“Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid 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 Medicaid programs. (42 CFR § 455.2)

Examples of Fraud, Waste and Abuse by a Provider

- Billing for services, procedures and/or supplies that have not actually been rendered.
- Providing services to patients that are not medically necessary.
- Balance Billing a Medicaid member for Medicaid covered services. For example, asking the patient to pay the difference between the discounted fees, negotiated fees, and the provider’s usual and customary fees.
- Intentional misrepresentation or manipulating the benefits payable for services, procedures and or supplies, dates on which services and/or treatments were rendered, medical record of service, condition treated or diagnosed, charges or reimbursement, identity of provider/practitioner or the recipient of services, “unbundling” of procedures, non-covered treatments to receive payment, “up-coding”, and billing for services not provided.
- Concealing patients misuse of Molina Healthcare of Florida identification card.
- Failure to report a patient’s forgery/alteration of a prescription.
- Knowingly and willfully soliciting/receiving payment of kickbacks or bribes in exchange for the referral of Medicaid patients.
- A physician knowingly and willfully referring Medicaid patients to health care facilities in which or with which the physician has a financial relationship. (The Stark Law)

Review of Provider

The Credentialing Department is responsible for monitoring practitioners through the various government reports, including:

- Federal and State Medicaid sanction reports.
- Federal and state lists of excluded individuals and entities including the Florida Agency for Healthcare Administration’s list of suspended and terminated providers at http://apps.ahca.myflorida.com/dm_web
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- Medicaid suspended and ineligible provider list.
- Monthly review of state Medical Board sanctions list.
- Review of license reports from the appropriate specialty board.

If a match is found, the Credentialing Services staff will request copies of relevant information from the appropriate government entity. Upon receiving this information the documents are
presented to the Credentialing Committee for review and potential action. The Credentialing staff will also present the list of physicians found on the Medicaid sanctions report to the Compliance Committee for review and potential oversight of action.

**Provider Profiling**

Molina Healthcare of Florida performs claims audits to detect potential external health care fraud, waste, or abuse. These audits of provider billings are based on objective and documented criteria. Molina Healthcare of Florida uses a fraud, waste, and abuse detection software application designed to score and profile provider and member billing behavior and patterns. The software utilizes a fraud finder engine to identify various billing behaviors, billing patterns, known schemes, as well as unknown patterns by taking into consideration a provider or member’s prior billing history. The software statistically identifies what is expected based on prior history and specialty norms, including recognition of pattern changes from those identified in profiled historical paid claims data and ongoing daily claims batches. If a score reaches a certain parameter or threshold, the provider or member is placed on a list for further review.

Molina Healthcare of Florida will inform the provider of the billing irregularities and request an explanation of the billing practices. The Compliance department, with the aid of the Special Investigation Unit, may conduct further investigation and take action as needed.

**Provider/Practitioner Education**

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

The Molina Healthcare of Florida Provider Services Representative will inform the provider’s office that an on-site meeting is required in order to educate the provider on certain issues identified as inappropriate or deficient.

**Review of Provider Claims and Claims System**

Molina Healthcare 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 preformed as authorized.

Molina Healthcare of Florida 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.
Cooperating with Special Investigation Unit Activities

Molina Healthcare’s Special Investigation Unit may conduct prepayment, concurrent, or post-payment review. Providers will cooperate with Special Investigation Unit activities, and will provide requested documentation to the unit following the timelines indicated in such requests. Failure to cooperate may result in further action, up to and including termination of the Provider contract.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Molina Healthcare AlertLine. AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare 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 Healthcare AlertLine can be reached toll free at 1-866-606-3889 or you may use the service’s website to make a report at any time at https://olinahealthcare.alertline.com
You may also report cases of fraud, waste or abuse to Molina Healthcare of Florida’s Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Florida
Attn: Compliance Department
8300 NW 33rd St, Suite 400
Doral, FL 33122

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, Medicaid ID number and any other identifying information.

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll- free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/
If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free (866) 966-7226 or (850) 414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General’s Office about keeping your identity confidential and protected.
Glossary of Terms

**Action** – The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

**Acute Inpatient Care** – Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending Provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the Provider

**AHCA** – Agency for Health Care Administration

**Ambulatory Care** – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

**Ambulatory Surgical Facility** – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

**Ancillary Services** – Health services ordered by a Provider, including but not limited to laboratory services, radiology services, and physical therapy.

**Appeal** – An oral or written request by a Member or Member’s personal representative received at Molina Healthcare for review of an action.

**Authorization** – Approval obtained by Providers from Molina Healthcare for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

**Average Length of Stay (ALOS)** – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

**Capitation** – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

**Centers for Medicare & Medicaid Services (CMS)** – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.
Children With Special Health Care Needs (CSHCN) – Children identified by HRSA as meeting the federal guidelines under Title V of the Social Security Act (SSA). Any child (birth to (18) years of age) with a health or developmental problem requiring more than the usual pediatric health care.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that Provider status be extended only to professional, competent Providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.


Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, Providers’ offices and home health care.

Denied Claims Review – The process for Providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a Provider.

Dual Coverage – When a Member is enrolled with two Molina Healthcare plans at the same time.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and
anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

**Emergency Care** – The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

**Encounter Data** – Molina Healthcare shall collect, and submit to the Agency’s fiscal agent, enrollee service level encounter data for all covered services.

**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.

**Expedited Appeal** – An oral or written request by a Member or Member’s personal representative received by Molina Healthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the Member’s life, health or ability to attain, maintain, or regain maximum function; or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

**Expedited Grievance** – A grievance where delay in resolution would jeopardize the Member’s life or materially jeopardize the Member’s health.

**Federally Qualified Health Center (FQHC)** – A facility that is:

I. Receiving grants under section 329, 330, or 340 of the Public Health Services Act

II. Receiving such grants based on the recommendation of AHCA within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant

III. A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638)

**Fee-For-Service (FFS)** – FFS is a term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a Member.

**Grievance** – An oral or written expression of dissatisfaction by a Member, or representative on behalf of a Member, about any matter other than an action received at Molina Healthcare.

**Health Plan Employer Data and Information Set (HEDIS)** – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers’ needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems,
Provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

HIPAA – Health Insurance Portability and Accountability Act

Independent Practice Association (IPA) – A legal entity, the Members of which are independent Providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the Member’s life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a Member.

Medically Necessary Services – FS 409.9131 (2) (b) Any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

- Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare Provider’s services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous Member of Molina Healthcare.

NCQA – National Committee for Quality Assurance
Participating Provider – A Provider that has a written agreement with Molina Healthcare to provide services to Members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of Providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a Provider or Provider group that may directly or indirectly have the effect of reducing or limiting services to Members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating Provider responsible 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 Practice Providers, General Medicine Providers, Internists, Obstetrician/Gynecologists, Physician Assistants (under the supervision of a Physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by Molina Healthcare.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another Provider for services or consultation which the referring Provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled Members.

Service Area – A geographic area serviced by Molina Healthcare, designated and approved by AHCA.

Specialist – Any licensed Provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Florida Kidcare/State Children’s Health Insurance Plan (SCHIP) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by HRSA.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA.

Sub-Contract – A written agreement between a health plan and a participating Provider, or between a participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.
Telemedicine — The practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than Molina Healthcare liable for payment of health care services rendered to Members. Molina Healthcare will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for SCHIP.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Well Child Visit (formerly known as CHCUP) – Early Periodic Screening Diagnosis and Treatment Program

******************************************************************************END OF HANDBOOK******************************************************************************
Molina Healthcare Prior Authorization Form

Molina Healthcare
Medicaid Prior Authorization/Pre-Service Request Form
Phone Number: 1 (855) 322-1076
Fax Number: 1 (866) 440-9791

<table>
<thead>
<tr>
<th>MEMBER INFORMATION</th>
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<tbody>
<tr>
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<td>Long-Term Care</td>
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<tr>
<td>Member Name:</td>
<td>DOB: / /</td>
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<tr>
<td>Member ID#:</td>
<td>Phone: ( ) -</td>
</tr>
<tr>
<td>Service Type: Elective/Routine</td>
<td>Expedited/Urgent*</td>
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</tbody>
</table>

*Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member’s health or could jeopardize the enrollee’s ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

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<thead>
<tr>
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<td>Outpatient: Surgical Procedure</td>
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<td>SNF:</td>
<td>Pain Management</td>
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<td>LTAC:</td>
<td>Other: Other:</td>
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<td>Home Health:</td>
<td>DME:</td>
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<td>CPT/HCPCS Code &amp; Description:</td>
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<tr>
<td>Strength/Dosage &amp; Frequency for above J-Codes**</td>
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<tr>
<td>Number of visits requested:</td>
<td>DOS From: / / to / /</td>
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Please send clinical notes and any supporting documentation.

**If multiple CPT or J-Codes, please submit this form along with a separate attachment.

<table>
<thead>
<tr>
<th>PROVIDER INFORMATION</th>
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<td>Servicing Provider or Facility:</td>
<td>NPI#:</td>
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<td>Contact at Requesting Provider’s office:</td>
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<tr>
<td>Phone Number: ( ) -</td>
<td>Fax Number: ( ) -</td>
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For Molina Use Only: