Provider Manual

Molina Healthcare of Ohio, Inc.

(Molina Healthcare or Molina)

2018 Molina Marketplace Product*
Effective 1/1/2018

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

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Section 1. Addresses and Phone Numbers

Provider Services Department

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

Provider Services	
Address:	Molina Healthcare of Ohio, Inc. P.O. Box 349020 Columbus, Ohio 43234-9020
Phone:	(855) 322-4079
Fax:	(888) 296-7851

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and Member complaints. Member Services Representatives are available 8:00 a.m. to 8:00 p.m. Monday through Friday, Saturday 8:00 a.m. to 6:00 p.m.excluding State holidays.

Member Services	
Address:	Molina Healthcare of Ohio, Inc. P.O. Box 349020 Columbus, Ohio 43234-9020
Phone:	(888)296-7677
TTY/TDD:	(800) 750-0750 or 711 (English)

Claims Department

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

- Access the Provider Portal (https://provider.molinahealthcare.com)
- EDI Payer ID 20149

To verify the status of your claims, please use Molina's Provider Portal. For other claims questions, contact Provider Services at (855) 322-4079

Claims

Phone:	(855) 322-4079

Claims Recovery Department

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

Claims Recovery	
Address	Molina Healthcare of Ohio, Inc. Dept. 781661 P.O. Box 78000 Detroit, MI 48278-1661
Phone:	(855)322-4079

Compliance and Fraud AlertLine

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

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

Credentialing Department

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

Credentialing	
Address:	Molina Healthcare of Ohio, Inc. P.O. Box 349020 Columbus, Ohio 43234-9020
Phone:	(855)322-4079
Fax:	(866) 713-1893

Nurse Advice Line

This telephone-based nurse advice line is available to all Molina Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available (24) hours a day, seven (7) days a week to assess symptoms and help make good health care decisions.

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

Healthcare Services (UM) Department

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

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

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

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

- Submit requests directly to Molina Healthcare via the Provider Portal. See our Provider Web Portal Quick Reference Guide or contact your Provider Services Representative for registration and submission guidance.
- Submit requests via 278 transactions. See the EDI transaction section of our website for guidance.

Healthcare Services **Authorizations & Inpatient Census**	
Provider Portal: https://provider.molinahealthcare.com	
Address:	Molina Healthcare of Ohio, Inc. P.O. Box 349020 Columbus, Ohio 43234-9020

Phone:	(855) 322-4079
Fax:	(855) 502-5130

Health Management

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

Weight Management and Smoking Cessations Programs	
Phone:	1 (866)-472-9483
Fax:	1-562-901-1176

Health Management Programs	
Phone:	1 (866) 891-2320
Fax:	1 (800) 642-3691

Behavioral Health

Molina Healthcare of Ohio, Inc. manages all components of our covered services for behavioral health. For Member behavioral health needs, please contact us directly at:

Behavioral Health	
Address:	Molina Healthcare of Ohio, Inc. P.O. Box 349020 Columbus, Ohio 43234-9020
Phone:	(855) 322-4079
(24) Hours per day, (365) day per year: Nurse Advice Line English (888) 275-8750 Spanish (866) 648-3537 TTY 711	

Pharmacy Department

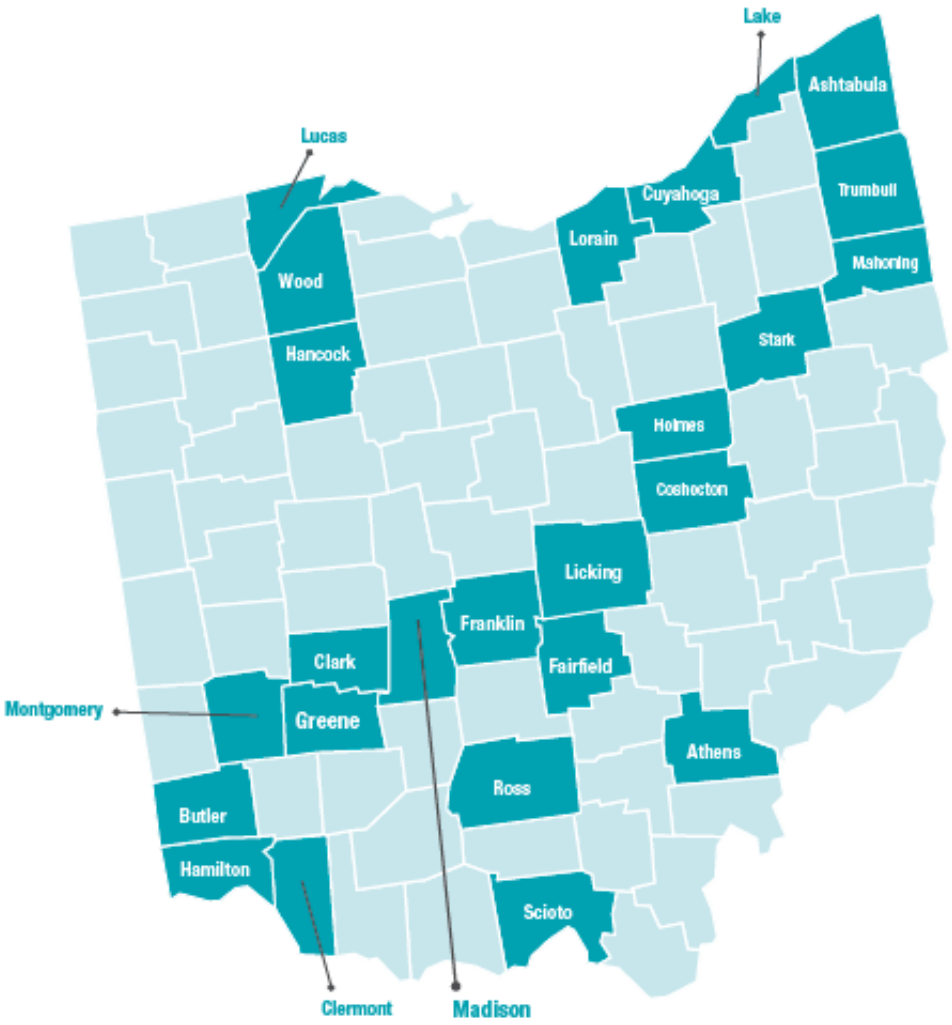
Prescription drugs are covered by Molina, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the molinaheathcare.com website, or by contacting Molina at (855) 322-4079.

Quality

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

Quality	
Phone:	(888) 296-7677

Molina Healthcare of Ohio, Inc. Service Area



Section 2. Provider Responsibilities

Nondiscrimination of Health Care Service Delivery

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

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

Section 1557 Investigations

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

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

Toll Free: (866) 606-3889
TTY/TDD: 711

On Line: https://molinahealthcare.AlertLine.com
Email: civil.rights@molinahealthcare.com

Facilities, Equipment and Personnel

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

Provider Data Accuracy and Validation

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

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact

Member access to care, Member assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Providers must validate the Provider Online Directory (POD) information at least quarterly for correctness and completeness. Providers must notify Molina in writing 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 at (855) 322-4079 if your information needs to be updated or corrected.

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

Molina is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. Providers are required to provide timely responses to such communications.

Molina Electronic Solutions Requirements

Molina requires Providers to utilize electronic solutions and tools.

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, 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, and submitting electronic claims upon entry into the network. Providers entering the network as a Contracted Provider must enroll for EFT/ERA payments within thirty (30) days of entering the Molina network.

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

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Molina Providers include:

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

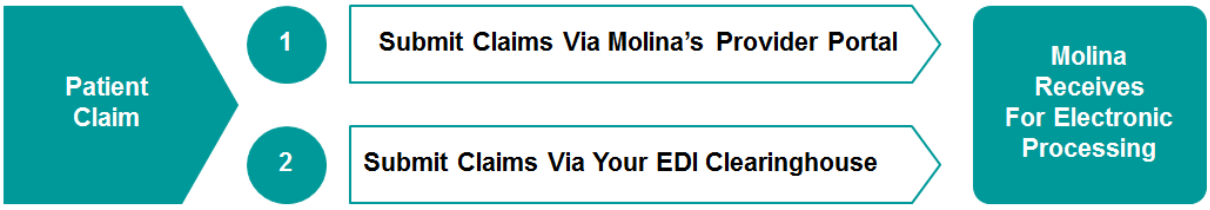
Electronic Claims Submission Requirement

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 via the Provider Portal. See our Provider Web Portal Quick Reference Guide https://provider.molinahealthcare.com or contact your Provider Services Representative for registration and Claim submission guidance.
- Submit Claims to Molina through your EDI clearinghouse using Payer ID 20149, refer to our website www.molinahealthcare.com for additional information.



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

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
    - Professional and Institutional Claims (individual or multiple claims)
    - Receive notification of Claims status change
    - Correct Claims
    - Void Claims
    - Add attachments to previously submitted claims
    - Check Claims status
    - Export Claims reports
    - Appeal Claims
- Prior Authorizations/Service Requests
    - Create and submit Prior Authorization Requests
    - Check status of Authorization Requests
    - 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 beyond copayments, deductibles or coinsurance.

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

For additional information please refer to the Compliance and Claims and Compensation sections of this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Molina Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and be approved by Molina prior to use. Please contact your Provider Services Representative for information and review of proposed materials.

Member Rights and Responsibilities

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

Member Eligibility Verification

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

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

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

Effective February 1, 2018, Molina Healthcare's policies will 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 that is a certified, full service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the 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 shall be compensated in accordance with your agreement with Molina Healthcare and applicable state and federal billing and payment rules and regulations.

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

Referrals

A referral is necessary when a Provider determines Medically Necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals (please refer to the Healthcare Services section of this Manual). Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document in the patient's medical record any referrals that are. Documentation needs to include the specialty, services requested, and diagnosis for which the referral is being made.

Providers should direct Members to health professionals, hospitals, laboratories, and other facilities and Providers which are contracted and credentialed (if applicable) with Molina Healthcare Marketplace. In the case of Emergency Services, Providers may direct Members to an appropriate service including but not limited to primary care, urgent care and Emergency Services. There may be circumstances in which referrals may require an out of network Provider; prior authorization will be required from Molina except in the case of Emergency Services.

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

Admissions

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

Participation in Utilization Review and Care Management Programs

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

Continuity and Coordination of Provider Communication

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

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

Molina Healthcare contracted providers should notify the Molina Healthcare Utilization Management department when providing care to pregnant members. This notification helps Molina Healthcare identify members who may need to be monitored for high-risk pregnancies.

Providers must also include the Last Menstrual Period (LMP) date in field 14 of the CMS 1500 claim form for pregnant members.

Hospitals are required to notify Molina Healthcare within 24 hours or the first business day of any inpatient admissions, including deliveries, in order for hospital services to be covered.

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 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 section of this Manual.

Site and Medical Record-Keeping Practice Reviews

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

Providers are required to maintain an accurate and readily available individual medical record for each Member to whom services are rendered. Providers are to initiate a medical record upon the Member's first visit. The Member's medical record (electronic preferred or hard copy) should contain all information required by State and Federal Law, generally accepted and prevailing professional practice, applicable government sponsored health programs and all Molina's policies and procedures. Providers are to retain all such records for a minimum of ten (10) years and retained further if the records are under review or audit until the review or audit is complete.

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

Delivery of Patient Care Information

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

Compliance

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

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

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

Additionally, Providers must comply with all HIPAA TCI (transactions, code sets, and identifiers) regulations. Providers must obtain a National Provider identifier (NPI) and use their NPI in HIPAA Transactions, including claims submitted to Molina.

Participation in Grievance and Appeals Programs

Providers are required to participate in Molina's Grievance Program and cooperate with Molina in identifying, processing, and promptly resolving all Member complaints, grievances, or

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

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

Participation in Credentialing

Providers are required to participate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable state and federal requirements. This includes providing prompt responses to requests for information related to the credentialing or re-credentialing process.

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

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

Delegation

Delegated entities must comply with the terms and conditions outlined in Molina's Delegation Policies and Delegated Services Addendum.

Section 3. Cultural Competency and Linguistic Services

Background

Molina works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the US Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Molina complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency and Members who are deaf, hard of hearing 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, gender, gender identity, sexual orientation, age and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at www.molinahealthcare.com, from your local Provider Services Representative and by calling Molina Provider Services at (855) 322-4079.

Nondiscrimination of Health Care Service Delivery

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

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

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

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

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

Molina Institute for Cultural Competency

Molina is committed to reducing health care disparities. Training employees, Providers and their staffs, and quality monitoring are the cornerstones of successful culturally competent service delivery. Molina 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, support Members with disabilities, and assist Members with Limited English Proficiency.

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

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

Program and Policy Review Guidelines

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

- Annual collection and analysis of race, ethnicity and language data from:
    - Eligible individuals to identify significant culturally and linguistically diverse populations 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.
- Determination of threshold languages annually 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

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

Members with Hearing Impairment

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

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

Molina will provide face-to-face service delivery for ASL to support our Members 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.

Section 4. Member Rights and Responsibilities

Providers must comply with the rights and responsibilities of Molina Members as outlined in the Molina Evidence of Coverage (EOC) and on the Molina Healthcare website. The EOC that is provided to Members annually is hereby incorporated into this Provider Manual. The most current Member Rights and Responsibilities can be accessed via the following link:

http://www.molinahealthcare.com/members/oh/en-US/mem/marketplace/quality/Pages/rights.aspx

EOCs are available on the Provider Portal and Molina's Member Website. Member Rights and Responsibilities are outlined under the heading "your Rights and Responsibilities" within the EOC document.

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

For additional information, please contact Molina Healthcare at (855) 322-4079, 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding State holidays. TTY users, please call 711.

Second opinions

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

Section 5. Eligibility, Enrollment, Disenrollment & Grace Period

Enrollment

Enrollment in Molina Healthcare of Ohio's Marketplace Program

The Centers for Medicare and Medicaid Services is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act. It is administered by the CMS on behalf of Ohio.

To enroll with Molina, the Member, his/her representative, or his/her responsible parent or guardian must follow enrollment process established by the Centers for Medicare and Medicaid Services who will enroll all eligible Members with the health plan of their choice.

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

Effective Date of Enrollment

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

Newborn Enrollment

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

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

Inpatient at time of Enrollment

With Member assistance, Molina may reach out to any prior Insurer (if applicable) to determine the Member's prior Insurer's liability for payment of Inpatient Hospital Services through discharge of any Inpatient admission. If there is no transition of care provision through Member's prior Insurer or Member did not have coverage through an Insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of Member's coverage with Molina, not prior.

Eligibility Verification

Health Insurance Marketplace Programs

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

Eligibility Listing for Molina Marketplace Programs

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

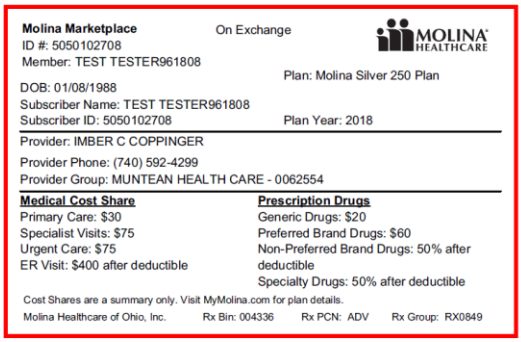
- Molina Provider Portal https://provider.molinahealthcare.com.
- Molina Provider Services at (855) 322-4079

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

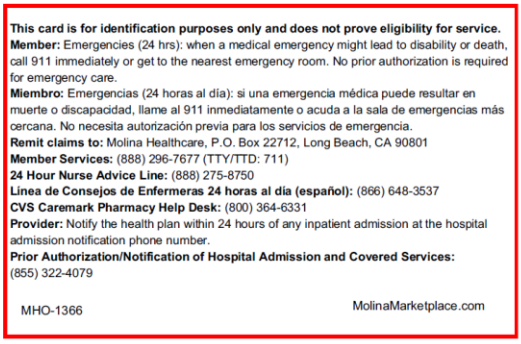
Identification Cards

Molina Healthcare of Ohio, Inc. Sample Member ID card

Card Front



Card Back



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

Disenrollment

Voluntary Disenrollment

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

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

Involuntary Disenrollment

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

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

PCP Assignment

Molina will offer each Member a choice of Primary Care Providers (PCPs). After making a choice, each Member will have a single PCP. Molina will assign a PCP to those Members who did not choose a PCP at the time of Molina selection. Molina will take into consideration the Member's last PCP (if the PCP is known and available in Molina 's contracted network), closest PCP to the Member's home address, ZIP code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN). Molina will allow pregnant Members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

PCP Changes

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

Grace Period

Definitions

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

Non-APTC Member: A Member who is not receiving any advanced premium tax credits, and is therefore solely responsible for the payment of the full monthly premium amount.

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

Summary

The Affordable Care Act mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a grace period in accordance with State Law to Non-APTC Members who fail to pay their monthly premium by the due date. To qualify for a grace period, the Member must have paid at least one full month's premium within the benefit year. The grace period begins on the first day of the first month for which the Member's premium has not been paid. The grace period is not a "rolling" period. Once the Member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace Period Timing

Non-APTC Members:

Non-ATPC Members are granted a 10 day grace period, during which they will not be able to access services under their benefit plan. If the *full past-due premium* is not paid by the end of the grace period, the Non-APTC Member will be terminated effective the last day of the month prior to the beginning of the grace period.

APTC Members:

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

Service Alerts

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

please refer to the Member Evidence of Coverage, or contact Molina's Provider Services Department at (855) 322-4079.

Notification

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

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

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

Prior Authorizations

All authorization requests will be reviewed based on Medical Necessity and will expire after 30 days. If a request for a prior authorization is made, the provider will receive the following disclaimer:

> "Prior Authorization is a review of medical necessity and is not a guarantee of payment for services. Payment will be made in accordance with a determination of the member's eligibility on the date of service (for Molina Marketplace members, this includes grace period status), benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement. If permitted under state law, Molina Healthcare will pend claims for services provided to Marketplace members in months 2 & 3 of the Federally-required grace period until such time as all outstanding premiums due are received or the grace period expires, whichever occurs first. For additional information on a Marketplace member's grace period status, please contact Molina Healthcare."

<u>APTC Members:</u>

If the APTC Member pays the full premium payment prior to the expiration of the 3 month grace period, Providers may then seek authorization for services. If the APTC Member received services during the second or third month of the grace period without a prior authorization, the Provider may request a retro-authorization for those services already rendered. All authorization requests will be reviewed based on Medical Necessity.

<u>Non-APTC Members:</u>

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

Claims Processing

APTC Members:

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

Second/Third Month of Grace Period: Clean Claims received while the APTC Member is in the grace period for services rendered during the second and third months of an APTC Member's grace period will be processed according to Molina's standard processes, within established turn-around-times, and in accordance with State and Federal statutes and regulations. In the event that the APTC Member is terminated for non-payment of the *full premium* prior to the end of the grace period, Molina will retroactively deny Claims for services rendered in the second and third months of the grace period, and will issue a re-coup notice to the Provider(s) if appropriate. Pharmacy Claims will be processed based on program drug utilization review and formulary edits; the APTC Member will be charged 100% of the discounted cost for prescriptions filled during the second and third months of the grace period.

Non-APTC Members:

Clean Claims received for services rendered during the grace period will be processed using Molina's standard processes and in accordance with State and Federal statutes and regulations and within established turn-around-times.

Section 6. Benefits and Covered Services

Molina covers the services described in the Summary of Benefits and Evidence of Coverage (EOC) documentation for each Molina Marketplace plan type. If there are questions as to whether a service is covered or requires prior authorization, please contact Molina at (855) 322-4079 between 8:00 a.m. – 5:00 p.m. ET.

Member Cost Sharing

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

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

Services Covered by Molina Links to Summaries of Benefits

The following web link provides access to the Summary of Benefits guides for the 2018 Molina Marketplace products offered in Ohio.

http://www.molinahealthcare.com/members/oh/en-US/mem/marketplace/coverd/Pages/allplans.aspx **Links to Evidence of Coverage**

Detailed information about benefits and services can be found in the 2018 Evidence of Coverage (EOC) booklets made available to Molina Marketplace Members. EOCs are available to Providers via the Provider Web Portal and on the Member website.

www.molinahealthcare.com/provider

Obtaining Access to Certain Covered Services

Prescription drugs

Prescription drugs are covered by Molina, via our pharmacy vendor, CVS Caremark. A list of in-network pharmacies is available on the molinaheathcare.com website, or by contacting Molina. Members must use their Molina ID card to get prescriptions filled. Additional information regarding the pharmacy benefits, and its limitations, is available by contacting Molina at (888) 296-7677, (855) 322-4079 or at www.molinahealthcare.com

Non-Formulary Drug Exception Request Process

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

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

- If the initial request is denied, an external review may be requested. The Member and/or Member's Representative and the prescribing Provider will be notified of the external review decision no later than:
    - 24 hours following receipt of the request for external review of the Expedited Exception Request
    - 72 hours following receipt of the request for external review of the Standard Exception Request

Mail Order Availability of Drug Formulary Prescription Drugs

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

Members may request mail order service in the following ways:

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

Injectable and Infusion Services

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

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

Access to Mental Health and Substance Abuse Services

Members in need of Mental Health or Substance Abuse Services can be referred by their PCP for services or Members can self-refer by calling Molina Healthcare's Behavioral Health Department at **(888) 296-7677**.

Molina's Nurse Advice Line is available 24 hours a day, 7 days a week for mental health or substance abuse needs. The services Members receive will be confidential. Additional detail regarding Covered Services and any limitations can be obtained in the EOCs linked above, or by contacting Molina. All outpatient professional mental health and substance abuse services will be charged the primary care copay equivalent.

Emergency Mental Health or Substance Abuse Services

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

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

Out of Area Emergencies

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

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

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

Obtaining Mental Health or Substance Abuse Services

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

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air or boat transports.

Non-Emergency Medical Transportation

For Molina Marketplace Members who have non-emergency medical transportation as a covered service, Molina covers transportation to medical facilities when the Member's medical and physical condition does not allow them to take regular means of public or private transportation (car, bus, etc.). This requires a written prescription from the Member's doctor. Examples of non-Emergency medical transportation include, but are not limited to, litter vans

and wheelchair accessible vans. Members must have Prior Authorization from Molina for ground and air ambulance services before the services are given. Prior Authorization not required for vans, taxi, etc. Additional information regarding the availability of this benefit is available by contacting Member Services at (888) 296-7677.

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:

- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email only
- Member cost sharing associates to the Schedule of Benefits [In New Mexico - Summary of Benefits and Coverage], based upon the Participating Provider's designation for Covered Services. (i.e. Primary Care, Specialist or Other Practitioner).
- Covered Services provided through Store and Forward technology, must include an in-person office visit to determine diagnosis or treatment.

Preventive Care

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

http://www.molinahealthcare.com/providers/common/marketplace/resource/Pages/hlthguide.aspx

We need your help conducting these regular exams in order to meet the targeted State and Federal standards. If you have questions or suggestions related to well child care, please call our Health Education line at (866) 472-9483.

Emergency Services

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

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

Nurse Advice Line

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

Nurse Advice Line (24 Hours)	
English Phone:	(888) 275-8750
Spanish Phone:	(866) 648-3537

TTY/TDD:	711 Relay
Or	
	(866) 735-2929 (English)
	(866) 833-4703 (Spanish)

Molina is committed to helping our Members:

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

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

Health Management Programs

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

- Asthma
- Depression
- Weight Management
- Smoking Cessation

For more info about our programs, please call:

- Provider Services Department at (855) 322-4079
- Visit www.molinahealthcare.com

Program Eligibility Criteria and Referral Source

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

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

- Pharmacy Claims data for all classifications of medications;
- Encounter Data or paid Claim with a relevant CMS accepted diagnosis or procedure code;
- Member Services welcome calls made by staff to new Member households and incoming Member calls have the potential to identify eligible program participants. Eligible Members are referred to the program registry;
- Provider referral;
- Nurse Advice referral;
- Medical Case Management or Utilization Management; and
- Member self-referral due to general plan promotion of program through Member newsletter, the Nurse Advice Line or other Member communication

Provider Participation

Contracted Providers are automatically notified whenever their patients are enrolled in a health management program. Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease;
- Clinical resources such as patient assessment forms and diagnostic tools;
- Patient education resources;
- Provider Newsletters promoting the health management programs, including how to enroll patients and outcomes of the programs;
- Clinical Practice Guidelines; and
- Preventive Health Guidelines;

Additional information on health management programs is available from your local Molina HCS Department **toll free at (855) 322-4079.**

Weight Management

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

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

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4079.

Smoking Cessation

Molina's Smoking Cessation Program uses a combination of telephonic outreach by a Care Managers to support the smoking cessation needs of the Member. The team works closely with the Member to develop a smoking cessation plan of care. Members are encouraged to work with their contracted Providers to determine appropriate pharmacological aid, as needed.

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

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4079.

Breathe with ease ^{SM} Program

Molina Healthcare provides an asthma health management program called breathe with ease^{SM}, 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.

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4079.

Building Brighter Days Adult Depression Management Program

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

To find out more information about the health management programs, please call Provider Services Department at (855) 322-4079.

Section 7. Healthcare Services

Introduction

Molina provides care management services to Marketplace Members using processes designed to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Molina utilizes an integrated care management model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Elements of the Molina medical management program include Pre-service review and Organization Determination/ Authorization management that includes pre-admission, admission and inpatient review, Medical Necessity review, and restrictions on the use of non-network Providers. You can contact the Molina UM Department for toll free at (855) 322-4079. The UM Department fax number is (855) 502-5130.

Utilization Management

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

- Identify medical necessity and appropriateness while managing benefits effectively and efficiently to ensure efficiency of the health care services provided
- Continually monitor, evaluate and optimize the use of health care resources while evaluating the necessity and efficiency of health care services across the continuum of care;
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization while monitoring utilization practice patterns of Providers, hospitals and ancillary Providers to identify over and under service utilization;
- Identify and assess the need for Care Management/Health Management through early identification of high or low service utilization and high cost, chronic or long term diseases;
- Promote health care in accordance with local, state and national standards;
- Identify events and patterns of care in which outcomes may be improved through efficiencies in UM, and to implement actions that improve performance by ensuring care is safe and accessible
- Ensuring that qualified health care professionals perform all components of the UM / CM processes while ensuring timely responses to Member appeals and grievances
- Continually seek to improve Member and Provider satisfaction with health care and with Molina utilization processes while ensuring that UM decision tools are appropriately applied in determining medical necessity decision.
- Process authorization requests timely and with adherence to all regulatory and accreditation timeliness standards.

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

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

Medical Necessity Review

Molina only reimburses for services that are Medically Necessary. To determine Medical Necessity, in conjunction with independent professional medical judgment, Molina will use nationally recognized guidelines, which include but are not limited to MCG (formerly known as Milliman Care Guidelines), McKesson 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/review, or retrospectively.

Clinical Information

Molina requires copies of clinical information be submitted for documentation in all Medical Necessity determination processes. Clinical information includes but is not limited to; physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Molina does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations or the Molina Hospital or Provider Services Agreement require such documentation to be acceptable.

Prior Authorization

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

Requests for prior authorizations to the UM Department may be sent by telephone, fax, mail based on the urgency of the requested service, or via the Provider Web Portal. Contact telephone numbers, fax numbers and addresses are noted in the introduction of this section. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number, etc.)
- Clinical information sufficient to document the Medical Necessity of the requested service
- Provider demographic information (referring Provider and referred to Provider/facility)
- Requested service/procedure, including all appropriate CPT, HCPCS, and ICD-10 codes
- Location where service will be performed
- Member diagnosis (CMS-approved diagnostic and procedure code and descriptions)
- Pertinent medical history (include treatment, diagnostic tests, examination data)
- Requested Length of stay (for inpatient requests)
- Indicate if request is for expedited or standard processing

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Prior Authorization is not a guarantee of payment. Payment is contingent upon Member eligibility at the time of service.

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

Providers who request Prior Authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina has a full-time Medical Director available to discuss Medical Necessity decisions with the requesting Provider at (855) 322-4079.

Inpatient at time of Termination of Coverage

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

Requesting Prior Authorization

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

Web Portal: Participating Providers are required to use the Molina Web Portal for prior authorization submissions whenever possible. Instructions for how to submit a Prior Authorization Request are available on the Portal.

Fax: The Prior Authorization form can be faxed to Molina at: (855) 502-5130. If the request is not on the form provided by Molina, be sure to send to the attention of the Healthcare Services Department. Please indicate on the fax if the request is urgent or non-urgent. **The Definition of expedited/urgent is when the situation where the standard time frame or decision making process (up to 14 days per Molina's process) could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function.** Please include the supporting documentation needed for Molina to make a determination along with the request to facilitate your request being made as expeditiously as possible

Phone: Prior Authorizations can be initiated by contacting Molina's Healthcare Services Department at (855) 322-4079. It may be necessary to submit additional documentation before the authorization can be processed.

Mail: Prior Authorization requests and supporting documentation can be submitted via U.S. Mail at the following address:

Molina Healthcare of Ohio
Attn: Healthcare Services Dept.
P.O. Box 349020
Columbus, Ohio 43234

Affirmative Statement about Incentives

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

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

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

Open Communication about Treatment

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

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

Utilization Management Functions Performed Exclusively by Molina

The following UM functions are conducted by Molina (or by an entity acting on behalf of Molina) and are never delegated:

1. Transplant Case Management - Molina does not delegate management of transplant cases to the medical group. Providers are required to notify Molina's UM Department when the need for a transplant evaluation has been identified. Contracted Providers must obtain prior authorization from Molina Medicare for transplant evaluations and surgery. Upon notification, Molina conducts medical necessity review. Molina selects the facility to be accessed for the evaluation and possible transplant.
2. Clinical Trials - Molina does not delegate to Providers the authority to determine and authorize clinical trials. Providers are required to comply with protocols, policies, and procedures for clinical trials as set forth in Molina's contracts.
3. Experimental and Investigational Reviews - Molina does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Delegated Utilization Management Functions

Medical Groups/IPAs delegated with UM functions must be prior approved by Molina and be in compliance with all current Molina policies. Molina may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities depending on their ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Molina policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual

Communication and Availability to Members and Providers

Molina HCS staff is accessible by calling (855) 322-4079 during normal business hours, Monday through Friday (except for Holidays) from 8:00 a.m. to 5:00 p.m. for information and authorization of care. When initiating, receiving or returning calls the UM staff will identify the organization, their name and title.

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

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff. Callers may also contact staff directly through a private line. All staff Members identify themselves by providing their first name, job title, and organization.

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

Molina's Provider Portal is available twenty-four (24) hours per day, seven (7) days per week. The Portal can be used for Prior Authorization functions (requests, status checks, etc.) and communication.

Levels of Administrative and Clinical Review

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

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

The overall review process begins with administrative review followed by initial clinical review if appropriate. Specialist review may be needed as well. All Determination/Authorization requests that may lead to denial are reviewed by a heath professional at Molina (medical director, pharmacy director, or appropriately licensed health professional).

All staff involved in the review process has an updated Determination/Authorization requirements list of services and procedures that require Pre-Service Organization Decision/Authorization.

The Determination/Authorization requirements, timelines and procedures are published in the Provider Manual and are available on the www.molinahealthcare.com website.

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

Hospitals

Emergency Services

Emergency Services means: Covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat or stabilize an emergency medical condition.

Emergency Medical Condition or Emergency means: The acute onset of a medical condition or psychiatric condition that has acute symptoms of sufficient severity (including severe pain), 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 result in:

- Placing the health of the Member (or in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or

- Serious dysfunction of any bodily organ or part.

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

Members accessing the emergency department inappropriately will be contacted by Molina Case Managers whenever possible to determine the reason for using Emergency Services. Case Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Admissions

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

Inpatient Management

Elective Inpatient Admissions

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

Emergent Inpatient Admissions

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

Inpatient at time of Termination of Coverage

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

Prospective/Pre-Service Review

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

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

Inpatient Review

Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. Molina requires that requested clinical information updates be received by Molina from the inpatient facility within twenty-four (24) hours of the request. Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Molina Healthcare will authorize hospital care as an inpatient, for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or where observation has been tried, in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed.

Inpatient Status Determinations

Molina's UM staff determine if the collected medical records and clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements. To determine Medical Necessity, the criteria outlined under "Medical Necessity Review" will be used.

Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. Upon discharge the Provider must provide Molina with Member demographic information, date of discharge, discharge plan and disposition.

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

Post-Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization. Failure to obtain authorization for an elective service that requires authorization will result in an administrative denial. Emergent services do not require authorization. Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied.

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

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

Readmission Policy

Hospital readmissions within thirty (30) days potentially constitute a quality of care problem. Readmission review is an important part of Molina Healthcare's Quality Improvement Program to ensure that Molina Healthcare Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Molina Healthcare will review all hospital subsequent admissions that occur within the time frames allowed by Federal and State Law of the previous discharge for all Claims. Reimbursement for readmissions will be limited to the payment for the first admission and the second payment will be denied unless it meets one of the exceptions noted below, violates between the Hospital and Molina Healthcare. If the readmission occurs at a different facility the second admission will be reimbursed and the payment to the first facility will not be eligible for payment due to readmission unless the case meets one of the exceptions noted below, violates State and/or Federal Law or violates the terms of the Hospital or Provider Services Agreement between the Hospital and Molina Healthcare

Exceptions

1. The readmission is determined to be due to an unrelated condition from the first inpatient admission AND there is no evidence that premature discharge or inadequate discharge planning in the first admission necessitated the second admission
2. The readmission is part of a Medically Necessary, prior authorized or staged treatment plan

3. There is clear medical record documentation that the patient left the hospital AMA during the first hospitalization prior to completion of treatment and discharge planning.

Definitions

Readmission: A subsequent admission to an acute care hospital within a specified time frame of a prior admission for a related condition or as readmission is defined by State Laws or regulations.

Related Condition: A condition that has a same or similar diagnosis or is a preventable complication of a condition that required treatment in the original hospital admission.

Non-Network Providers and Services

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

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

“Emergency Services” means health care services needed to evaluate, stabilize or treat an Emergency Medical Condition.

Avoiding Conflict of Interest

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

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

Coordination of Care and Services

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

Molina staff assists Providers by identifying needs and issues that may not be verbalized by Providers, assisting to identify resources such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Molina staff is done in partnership with Providers and Members to ensure efforts are efficient and non-duplicative.

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

Continuity of Care and Transition of Members

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

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

For additional information regarding continuity of care and transition of Members, please contact Molina at (855) 322-4079.

Organization Decisions

A decision is any determination (e.g., an approval or denial) made by Molina or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination);
- Determination to deny requests (adverse determination);
- Discontinuation of a service;
- Payment for temporarily out-of-the-area renal dialysis services;
- Payment for Emergency Services, post stabilization care or urgently needed services;

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

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

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

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

Providers can contact Molina's Healthcare Services department at (855) 322-4079 to obtain Molina's UM Criteria.

Reporting of Suspected Abuse of an Adult

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

Molina reports suspected or potential abuse, neglect or exploitation of vulnerable adults as required by state and Federal law. A vulnerable adult is defined as a person who is not able to defend themselves, protect themselves, or get help for themselves when injured or emotionally abused. A person may be vulnerable because of a physical condition or illness (such as weakness in an older adult or physical disability) or a mental/behavioral or emotional condition. Mandatory reporters include:

- Molina employees who have knowledge or suspect the abuse, neglect, or exploitation;
- Law enforcement officer;
- Social worker; Professional school personnel; Individual Provider; an employee of a facility; an operator or a facility; and/or
- An employee of a social service, welfare, mental/behavioral health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science Provider or health care Provider.

A permissive reporter is any individual with knowledge of a potential abuse situation who is not included in the list of mandatory reporters. A permissive reporter may report to the Molina UM Department or a law enforcement agency when there is reasonable cause to believe that a vulnerable adult is being or has been abandoned, abused, financially exploited or neglected. Permissive or voluntary reporting will occur as needed.

The following are the types of abuse which are required to be reported:

- Physical abuse is intentional bodily injury. Some examples include slapping, pinching, choking, kicking, shoving, or inappropriately using drugs or physical restraints.
- Sexual abuse is nonconsensual sexual contact. Examples include unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.
- Mental/behavioral mistreatment is deliberately causing mental or emotional pain. Examples include intimidation, coercion, ridiculing; harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; and yelling or swearing which results in mental distress.
- Neglect occurs when someone, either through action or inaction, deprives a vulnerable adult of care necessary to maintain physical or mental health.
- Self-neglect occurs when a vulnerable adult fails to provide adequately for themselves. A competent person who decides to live their life in a manner which may threaten their safety or well-being does not come under this definition.
- Exploitation occurs when a vulnerable adult or the resources or income of a vulnerable adult are illegally or improperly used for another person's profit or gain.
- Abandonment occurs when a vulnerable adult is left without the ability to obtain necessary food, clothing, shelter or health care.

In the event that an employee of Molina or one of its contracted Providers encounters potential or suspected abuse as described above, a call must be made to Ohio Adult Protective Services at 1-855-OHIO-APS (1-855-644-6277) toll-free 24/7.

All reports should include:

- Date abuse occurred;
- Type of abuse;
- Names of persons involved if known;
- Any safety concerns.

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

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

Emergency Services

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

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

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

For Members within our service area: Molina Healthcare of Ohio, Inc. contracts with vendors that provide (24) hour Emergency Services for ambulance and hospitals. An out of network Emergency hospital stay will be covered until the Member has stabilized sufficiently to transfer to a Participating Provider facility. Services provided after stabilization in a Non-Participating Provider facility are not covered, and Member will be responsible for payment. Member payments to the Non-Participating Provider facility will not apply to the Member's Deductible or Annual Out-of-Pocket Maximum.

Continuity and Coordination of Provider Communication

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

Molina Care Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services.

PCP Responsibilities in Care Management Referrals

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

Care Manager Responsibilities

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

- Monitors and communicates the progress of the implemented plan of care to all involved resources
- Serves as a coordinator and resource to team Members throughout the implementation of the plan, and makes revisions to the plan as suggested and needed
- Coordinates appropriate education and encourages the Member's role in self-help
- Monitors progress toward the Member's achievement of treatment plan goals in order to determine an appropriate time for the Member's discharge from the CM program.

Health Management

Molina's Health Management programs can be incorporated into the Member's treatment plan to address the Member's health care needs. Primary prevention programs may include smoking

cessation, weight management, pregnancies, and disease-specific health management programs for Asthma and Depression. Refer to “Benefits and Covered Services” section for detailed information regarding these services.

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

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

Case Management (CM)

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

The Molina case managers are licensed professionals and are educated, trained and experienced in the Care Management process. The CM program is based on a Member advocacy philosophy, designed and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The CM program is individualized to accommodate a Member’s needs with collaboration and approval from the Member’s PCP. The Molina case manager will arrange individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Molina case manager is responsible for assessing the Member’s appropriateness for the CM program and for notifying the PCP of the evaluation results, as well as making a recommendation for a treatment plan.

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

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

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

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

Medical Record Standards

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

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

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

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

At a minimum, each medical record must be legible and maintained in detail with the documentation outlined in the Quality section of this Provider Manual. Medical records shall be maintained in accordance with State and Federal law, and for a period not less than ten (10) years.

Medical Necessity Standards

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

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

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary, a Medical Necessity or a Covered Service/Benefit.

Specialty Pharmaceuticals/Injectables and Infusion Services

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

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

Experimental and Investigational Services are not Covered

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be Experimental/Investigational is not covered.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigational based on the criteria above may still be deemed Experimental/Investigational by Us. In determining whether a Service is Experimental/Investigational, We will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service or drug on health outcomes;
- The evidence demonstrates the service or drug improves net health outcomes of the total population for whom the service or drug might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service or drug has been shown to be as beneficial for the total population for whom the service or drug might be proposed as any established alternatives; and
- The evidence demonstrates the service or drug has been shown to improve the net health outcomes of the total population for whom the service or drug might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other Federal, State or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Whether there is FDA approval for the use for which benefits are sought; or
- Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational.

This exclusion does not apply to services covered under “Approved Clinical Trials” in the “What is Covered Under My Plan?” section.

Please refer to the “Claims Decisions, Internal Appeals, and External Review” section for information about Independent Medical Review related to denied requests for Experimental or Investigational services

Section 8. Quality

Quality Improvement

Molina maintains a Quality Department to work with Members and Providers in administering the Molina Quality Improvement Program. You can contact the Molina Quality Department **toll free at (855) 322-4079.**

The address for mail requests is:

Molina Healthcare of Ohio, Inc.
Quality Improvement Department
P.O. Box 349020
Columbus, Ohio 43234

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

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

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

- Have a Quality Improvement Program in place;
- Comply with and participate in Molina's Quality Improvement Program including reporting of Access and Availability and provision of medical records as part of the HEDIS® review process; and
- Allow access to Molina Quality personnel for site and medical record review processes.

Patient Safety Program

Molina's Patient Safety Program identifies appropriate safety projects and error avoidance for Molina Members in collaboration with their Primary Care Providers. Molina continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and case management/disease management programs and education. Molina monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) is to identify areas that have the potential for improving health care quality to reduce the incidence of events.

Quality of Care

Molina has an established and systematic process to identify, investigate, review and report any Quality of Care, Adverse Event/Never Event, and/or service issues affecting Member care. Molina will research, resolve, track and trend issues. Confirmed Adverse Events/Never Events

are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

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

Medical Records

Molina requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. Molina conducts a medical record review of all Primary Care Providers (PCPs) that have a 50 or more Member assignment that includes the following components:

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

Medical Record Keeping Practices

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

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

Content

Providers must demonstrate compliance with Molina's medical record documentation guidelines. Medical records are assessed based on the following standards:

- Patient name or ID is on all pages;
- Current biographical data is maintained in the medical record or database;
- All entries contain author identification;
- All entries are dated;

- Problem list, including medical and behavioral health conditions;
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Allergies and adverse reactions are prominently displayed. Absence of allergies is noted in easily recognizable location;
- Advanced Directives are documented for those 18 years and older;
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints and provides a risk assessment of the Member's health status;
- Chronic conditions are listed or noted in easily recognizable location;
- Treatment plans are consistent with diagnosis
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query;
- The history and physical examination identifies appropriate subjective and objective information pertinent to a patient's presenting complaints and provides a risk assessment of the Members health status;
- Chronic conditions are listed or noted in easily recognizable location;
- Treatment plans are consistent with diagnoses;
- There is appropriate notation concerning use of substances, and for patients, there is evidence of substance abuse query;
- Consistent charting of treatment care plan;
- Working diagnoses are consistent with findings;
- Encounter notation includes follow up care, call, or return instructions;
- Preventive health measures (i.e., immunizations, mammograms, etc.) are noted;
- A system is in place to document telephone contacts;
- Lab and other studies are ordered as appropriate and filed in chart;
- Lab and other studies are initialed by ordering Provider upon review;
- If patient was referred for consult, therapy, or ancillary service, a report or notation of result is noted at subsequent visit, or filed in medical record; and
- If the Provider admitted a patient to the hospital in the past twelve (12) months, the discharge summary must be filed in the medical record;
- Developmental screenings as conducted through a standardized screening tool.
- Documentation of the age-appropriate screening that was provided in accordance with the periodicity schedule and all EPSDT related services.
- Documentation of a pregnant Member's refusal to consent to testing for HIV infection and any recommended treatment.

Organization

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

Retrieval

- The medical record is available to Provider at each Encounter;
- The medical record is available to Molina for purposes of Quality Improvement;
- The medical record is available to the External Quality Review Organization upon request;
- The medical record is available to the Member upon their request;
- Medical record retention process is consistent with State and Federal requirements and record is maintained for not less than ten (10) years; and
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

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

- Ensure that medical information is released only in accordance with applicable Federal or State law in pursuant to court orders or subpoenas;
- Maintain records and information in an accurate and timely manner;
- Ensure timely access by Members to the records and information that pertain to them;
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health an enrollment information;
- Medical Records are protected from unauthorized access;
- Access to computerized confidential information is restricted; and
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.

Additional information on medical records is available from your local Molina Quality Improvement Department **toll free at (855) 322-4079**. See also the Compliance Section of this Provider Manual for additional information regarding the Health Insurance Portability and Accountability Act (HIPAA).

Access to Care

Molina maintains access to care standards and processes for ongoing monitoring of access to health care (including behavioral health care) provided by contracted primary PCPs (adult and pediatric) and participating specialist (to include OB/GYN, behavioral health providers, and high volume and high impact specialists). Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 95% availability for Emergency Services and 80% or greater for all other services. The PCP or his/her designee must be available 24 hours a day, 7 days a week to Members.

Appointment Access

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

Category	Type of Care	Access Standard
PCP (general practitioners, internist, family practitioners, pediatricians)	Preventive/routine care	Within six weeks
	Urgent care	By the end of the following work day
	Emergent care	Triaged and treated immediately
	After hours	Available by phone 24 hours a day, seven days a week
OB/GYN	Pregnancy (initial visit)	Within two weeks
	Routine visit	Within six weeks
Orthopedist	Routine visit	Within eight weeks
Otolaryngologist (ENT)	Routine visit	Within six weeks
Dermatologist	Routine visit	Within eight weeks
Dental	Routine visit	Within six weeks
Endocrinologist	Routine visit	Within eight weeks
Allergist	Routine visit	Within eight weeks
Neurologist	Routine visit	Within eight weeks
Behavioral health	Routine care	Within 10 business days
	Urgent care	Within 48 hours
	Non-life threatening emergency	Within six hours
	After hours	Available by phone 24 hours a day, seven days a week

All other non-primary (Specialty) care	Routine care	Within six weeks
All	Office wait time	Maximum of 30 minutes

Additional information on appointment access standards is available from your local Molina QI Department **toll free at (855) 322-4079.**

Office Wait Time

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

After Hours

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

Appointment Scheduling

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

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record. If a second appointment is missed, the Provider is to notify the **Molina Provider Services Department toll free at (855) 322-4079 or TTY/TDD 711;**
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national

origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost care. If a PCP chooses to close his/her panel to new Members, Molina must receive thirty (30) days advance written notice from the Provider.

Women's Health Access

Molina allows Members the option to seek obstetrical and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by Molina as providing obstetrical and gynecological services. Member access to obstetrical and gynecological services is monitored to ensure Members have direct access to Participating Providers for obstetrical and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available under the Resources tab on the Molinahealthcare.com website or from your local Molina QI Department **toll free at (855) 322-4079.**

Monitoring Access Standards

Molina monitors compliance with the established access standards above. At least annually, Molina conducts an access audit of randomly selected contracted Provider offices to determine if appointment access standards are met. All appointment standards are addressed. Results of the audit are distributed to the Providers after its completion. A corrective action plan may be required if standards are not met. In addition, Molina's Member Services Department reviews Grievances and Appeals related to delays in access to care. These are reported quarterly to committees. Delays in access that may create a potential quality issue are sent to the QI Department for review.

Additional information on access to care is available under the Resources tab at Molinahealthcare.com or is available from your local Molina QI Department **toll free at (855) 322-4079.**

Quality of Provider Office Sites

Molina has a process to ensure that the offices of all Providers meet its office-site and medical record keeping practices standards. Molina continually monitors Member complaints for all office sites to determine the need of an office site visit and will conduct office site visits within sixty (60) calendar days. Molina assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This form includes the Office Site Review Guidelines and the Medical Record Keeping Practice Guidelines (as outlined above under Medical Records heading) and the thresholds for acceptable performance against the criteria. This includes an assessment of:

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

Physical accessibility

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

Physical appearance

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

Adequacy of waiting and examining room space

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

Adequacy of medical record-keeping practices

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

Monitoring Office Site Review Guidelines and Compliance Standards

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

Administration & Confidentiality of Facilities

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

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and parking area and walkways demonstrate appropriate maintenance.
- Handicapped parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is handicapped accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per physician.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available
- Yearly OSHA training (Fire, Safety, Blood borne Pathogens, etc.) is documented for offices with 10 or more employees.

- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence hazardous waste management.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectibles and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Improvement Plans/Corrective Action Plans

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

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

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

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

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

Advance Directives (Patient Self-Determination Act)

Molina complies with the advance directives requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information

regarding advance directives and that contracted Providers and facilities uphold executed documents**.**

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

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

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

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

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

Members who would like more information are instructed to contact Member Services or are directed to the Caring Connections website at http://www.caringinfo.org/stateaddownload for forms available to download. Additionally, the Molina website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

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

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

Services to Enrollees Under Twenty-One (21) Years

Molina maintains systematic and robust monitoring mechanisms to ensure all Enrollees under twenty-one (21) years are timely according to required preventive health guidelines. All Enrollees under twenty-one (21) years of age should receive screening examinations including appropriate childhood immunizations at intervals as specified by the by the preventive health

guidelines located on the Molina Website (www.molinahealthcare.com) and referenced in the Benefits and Covered Services section of this Provider Manual.

Well child / adolescent visits

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

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

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

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

Monitoring for Compliance with Standards

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

Quality Improvement Activities and Programs

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

Health Management

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

Care Management

Molina's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining best possible care outcomes to meet the Member's needs so they receive the right care, at the right time, and at the right setting. Molina Healthcare Management includes Health Management (HM) and Case Management (CM) programs. Members may qualify for HM or CM based on confirmed diagnosis or specified criteria for the programs. These comprehensive programs are available for all Members that meet the criteria for services. For additional information please see the Care Management heading in the Healthcare Services section of this Provider Manual.

Clinical Practice Guidelines

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

Molina Clinical Practice Guidelines include the following:

- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Obesity

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services Departments. The guidelines are disseminated through Provider newsletters, Just the Fax electronic bulletins and other media and are available on the Molina website. Individual Providers or Members may request copies from the local Molina QI Department **toll free (855) 322-4079.**

Preventive Health Guidelines

Molina provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF) and in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Perinatal/Prenatal Care

- Care for children up to 24 months old
- Care for children 2-19 years old
- Care for adults 20-64 years old
- Care for adults 65 years and older
- Immunization schedules for children and adolescents
- Immunization schedules for adults

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

Cultural and Linguistic Services

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

Measurement of Clinical and Service Quality

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

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

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

Contracted Providers and Facilities must allow Molina to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced Member cost sharing.

Molina's most recent results can be obtained from your local Molina QI Department toll free at (855) 322-4079 or by visiting our website at www.molinahealthcare.com.

HEDIS®

Molina utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, pre-natal visits, diabetes care, and cardiovascular disease.

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

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

ECHO® Survey

The Experience of Care and Health Outcomes (ECHO®) 3.0 Survey is an NCQA-endorsed tool that assesses the experience, needs, and perceptions of Members with their behavioral health care. Similar to CAHPS®, the ECHO® survey for adults produce the following measures of patient experience:

- Getting treatment quickly
- How well clinicians communicate
- Getting treatment and information from the plan
- Perceived improvement
- Information about treatment options
- Overall rating of counseling and treatment
- Overall rating of the health plan

The ECHO® Survey will be administered annually to selected Members by an NCQA-certified vendor.

Qualified Health Plan (QHP) Enrollee Experience Survey

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

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

QHP Enrollee Survey topics include:

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

- Shared decision-making
- Specialized services

Provider Satisfaction Survey

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

Effectiveness of Quality Improvement Initiatives

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

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

Quality Rating System

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

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

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

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

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

Section 9. Compliance

Fraud, Waste, and Abuse

Introduction

Molina is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Molina's Compliance department maintains a comprehensive plan, which addresses how Molina will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The program also addresses fraud, waste and abuse prevention and detection along with and the education of appropriate employees, vendors, Providers and associates doing business with Molina Healthcare of Ohio.

Mission Statement

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

Regulatory Requirements

Federal False Claims Act

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

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

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

The act does not require proof of a specific intent to defraud the U.S. Government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the Government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

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.

Waste:

Health care spending that can be eliminated without reducing the quality of care. Quality waste includes, overuse, underuse, and ineffective use. Inefficiency waste includes redundancy,

delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g. coding) causing unnecessary costs to the Marketplace program.

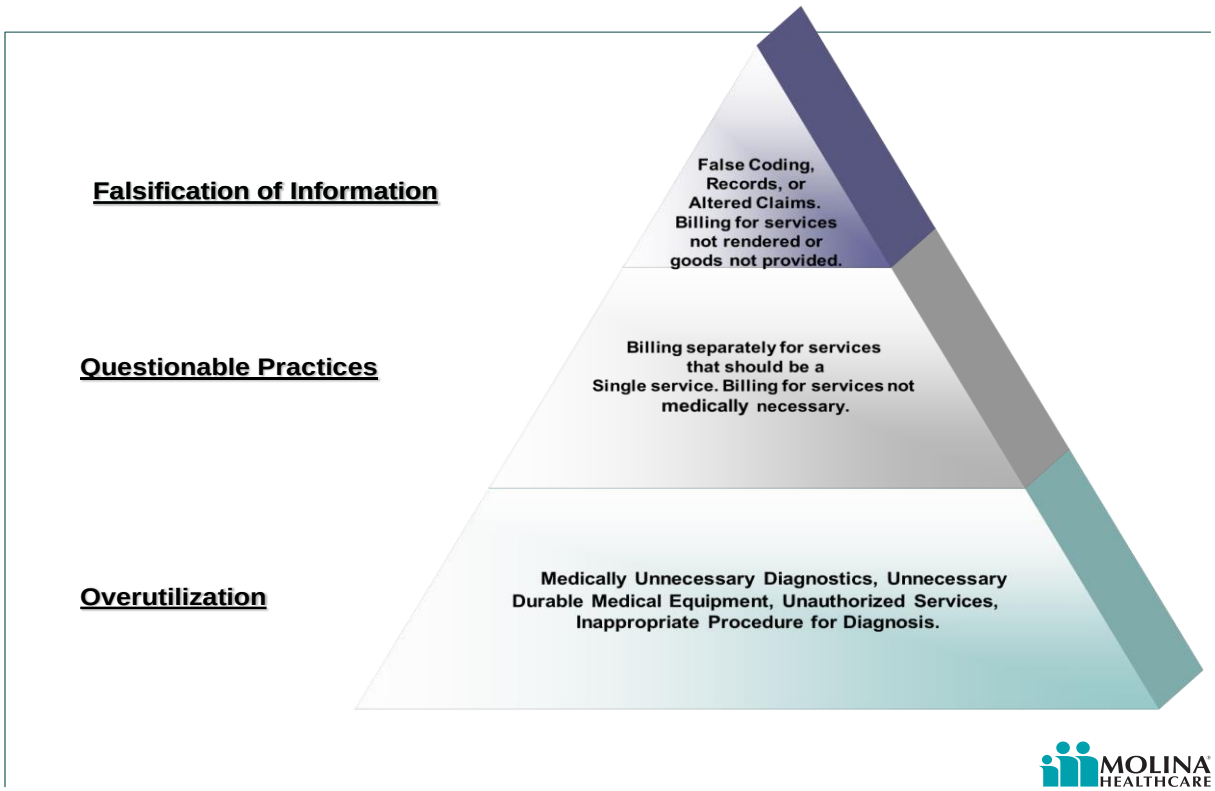
Abuse:

"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

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

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



Examples of Fraud, Waste, and Abuse by a Member

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

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

Review of Provider Claims and Claims System

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

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

Molina performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are

identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

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

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Molina under the Provider Agreement or at Law or equity. In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Molina shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

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

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

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

Review of Provider

The Credentialing Department is responsible for monitoring Providers through the various Government reports, including:

- Federal and State sanction reports.

- Federal and State lists of excluded individuals and entities including the Ohio Office of Inspector General's exclusion list.
- List of parties excluded from Federal Procurement and Non-procurement Programs.
- 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 sanctions report to the Compliance Committee for review and potential oversight of action.

Provider Education

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

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

Reporting Fraud, Waste and Abuse

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

Molina AlertLine can be reached toll free at 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's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Ohio
Attn: Compliance
3000 Corporate Exchange Drive
Columbus, Ohio 43231

Remember to include the following information when reporting:

- Nature of complaint.

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

Suspected fraud and abuse may also be reported directly to the Ohio Attorney General's Officeat:

Phone (614) 466-0722

HIPAA Requirements and Information

HIPAA (The Health Insurance Portability and Accountability Act)

Molina's Commitment to Patient Privacy

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

Provider Responsibilities

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

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

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

Applicable Laws

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

1. **Federal Laws and Regulations**
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - Medicare and Medicaid Laws
   - The Affordable Care Act

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

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

Uses and Disclosures of PHI

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

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

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

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

Confidentiality of Alcohol and Substance Abuse Patient Records

Federal Alcohol or Substance Abuse Confidentiality Regulations apply to any entity or individual providing federally assisted alcohol or drug abuse prevention functions. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with alcohol or drug abuse treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance abuse information, the federal alcohol and substance abuse regulations are more restrictive than

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

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

HIPAA and they do not allow disclosure without the Member's written consent except in very limited circumstances

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

Patient Rights

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

1. **Notice of Privacy Practices**

   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**

   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**

   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**

   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**

   Patients have a right to request that the Provider amend information in their designated record set.

6. Request Accounting of PHI Disclosures

Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Molina Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cyber security measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Molina.

HIPAA Transactions and Code Sets

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

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

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

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. And then click on the tab titled "HIPAA Transaction Readiness" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions. For Claims with dates of service prior to October 1, 2015, ICD-9 coding must be used. For Claims with dates of service on or after October 1, 2015, Providers must use the ICD-10 code sets.

National Provider Identifier

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

Additional Requirements for Delegated Providers

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

Reimbursement for Copies of PHI

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

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

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member Name:_____ Member ID #:_____

Member Address:_____ Date of Birth:_____

City/State/Zip:_____ Telephone #:_____

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

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

_____

_____

_____

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

_____

_____

_____

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

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

The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No____

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

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

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

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

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

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

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

This authorization expires on the following date or event*:

_____

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

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

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

Section 10. Claims and Compensation

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

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

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably 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 though a clearinghouse or Molina's Provider Portal, and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims) and use electronic Payer ID number: 20149**.** 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 20149

Provider Portal:

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

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

Clearinghouse:

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

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

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claims from your clearinghouse
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider may call the Molina EDI Customer Service line at (866) 409-2935 or email us at EDI.Claims@molinahealthcare.com for additional support.

Paper Claim Submissions

Effective July 1, 2017, participating providers should submit claims electronically. If electronic submission is not possible, please submit paper claims to the following address:

Molina Healthcare of Ohio
P.O. Box 22712
Long Beach, CA 90801

Coordination of Benefits and Third Party Liability

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

Timely Claim Filing

Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina, and shall include any and all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within one-hundred-twenty (120) calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Molina is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Molina within ninety (90) calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Reimbursement Guidance and Payment Guidelines

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

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

- Manuals and RVU files published by the Centers for Medicare and Medicaid Services (CMS), including:

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

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010. Molina Healthcare, Inc. uses NCCI standard payment methodologies.

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

General Coding Requirements

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

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure

proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. **Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s).** For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS codes

Effective 10/01/2015, Molina will utilize ICD-10-CM and PCS billing rules, and will deny claims that do not meet Molina's ICD-10 Claim Submission Guidelines. In order to ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

- Providers must submit ICD-10 codes for DOS or discharge on or after 10/01/2015. Claims containing ICD-9 codes for DOS on or after October 1, 2015, will be denied. Providers will be required to re-submit these claims with the appropriate ICD-10 code.
- If an inpatient hospital claim spans 9/30 & 10/1 and has an admission and/or from date prior to 10/1/15, then the entire claim should be billed using ICD-10 codes.
- Molina will deny all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim.
- Molina will only accept ICD-10 codes comprised of upper case characters. Any claim submitted with ICD-10 codes comprised of lower case characters will be denied.

Place of Service (POS) Codes

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

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a “frequency” code. For a complete list of codes, reference the National Uniform Billing Committee’s (NUBC’s) Official UB-04 Data Specifications Manual.

Revenue Codes

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

Diagnosis Related Group (DRG)

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

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

NDC

Effective May 1, 2014 the 11 digit National Drug Code Number (NDC) must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, UB-04 or its electronic equivalent.

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

Coding Sources

Definitions

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

- Category I Code – Procedures/Services

- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

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

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

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

Claim Auditing

Provider acknowledges Molina's right to conduct post-payment billing audits. Provider shall cooperate with Molina's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Molina shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Molina's policies and data to determine the appropriateness of the billing, coding, and payment.

Corrected Claims

Corrected Claims are considered new Claims for processing purposes. Corrected Claims must be submitted electronically with the appropriate fields on the 837I or 837P completed. Molina's Provider Portal includes functionality to submit corrected Institutional and Professional claims. Corrected claims must include the correct coding to denote if the claim is Replacement of Prior Claim or Corrected Claim for an 837I or the correct Resubmission Code for an 837P. **Claims submitted without the correct coding will be returned to the Provider for resubmission.**

EDI (Clearinghouse) Submission:

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- 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).

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

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider’s contract. Unless the Provider and Molina or contracted medical group/IPA have agreed in writing to an alternate schedule, Molina will process the claim for service within thirty (30) days after receipt of Clean Claims.

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

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at 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-hundred-twenty (120) days of Molina’s original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must

be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. *The form must be filled out completely in order to be processed*. Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following:

Providers should submit the following documentation:

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

Forms may be submitted via fax mail. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address:

Molina Healthcare of Ohio, Inc.
Attention: Claims Disputes / Adjustments
P.O. Box 349020
Columbus, Ohio 43234

Submitted via fax:

(800) 499-3406

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

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

Billing the Member

- Providers contracted with Molina cannot bill the Member for any covered benefits. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.
- Providers agree that under no circumstance shall a Member be liable to the Provider for any sums owed by Molina to the Provider
- Provider agrees to accept payment from Molina as payment in full, or bill the appropriate responsible party
- Provider may not bill a Molina Member for any unpaid portion of the bill or for a claim that is not paid with the following exceptions:
    - The Member has been advised by the Provider that the service is not a covered benefit and the Provider has documentation.
    - The Member has been advised by the Provider that he/she is not contracted with Molina and has documentation.

- The Member agrees in writing to have the service provided with full knowledge that they are financially responsible for payment.

Fraud and Abuse

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

Encounter Data

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

Encounter data must be submitted at least once per month, and within thirty-five (35) days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D -- Dental. Data must be submitted with Claims level detail for all non-institutional services provided. For institutional services, only those services covered by Molina should be reported.

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

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

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

When your Encounters are filed electronically you should receive:

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

Section 11. Complaints, Grievance and Appeals Process

Member Complaints

What is a Member Complaint?

A complaint is any dissatisfaction that a Member has with Molina or any Participating Provider that is not related to the denial of health care services. For example, a Member may be dissatisfied with the hours of availability of a Provider. A complaint does not include issues relating to the denial of health care services. Issues relating to the denial of health care services are Appeals, and should be filed with Molina or the Ohio Department of Insurance in the manner described in the Internal Appeals section below.

Filing Member Complaints

Molina recognizes the fact that Members may not always be satisfied with the care and services provided by our Network Providers, hospitals and other providers. Molina Healthcare wants to know about Member concerns and any complaints Members may have. Members may file a complaint in writing or by calling us. Molina Healthcare will respond to Member complaints no later than 60 days from when the complaint is received.

Members who have a complaint can contact Molina for assistance at the following:

Appeals and Grievances Department	
Address:	Molina Healthcare of Ohio, Inc. Appeals and Grievance Department P.O. Box 349020 Columbus, Ohio 43234-9020
Telephone:	(888) 296-7677, Monday – Friday 8:00 am – 8:00 pm EST Saturday 8:00 am – 6:00 pm EST
TTY:	(800) 750-0750 or 711
Website:	www.molinahealthcare.com

Ohio Department of Insurance Consumer Affairs	
Address:	Ohio Department of Insurance ATTN: Consumer Affairs 50 West Town St. Suite 300 Columbus, Ohio 43215
Telephone:	(800) 686-1526

Telephone:	(614) 644-2673
Fax:	(614) 644-3744
TTY:	(614) 644-3745
Website:	https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File Online Consumer Complaint:	http://insurance.ohio.gov/Consumer/OCS/Pages?ConsCompl.aspx

Ohio Member Appeals process and timeline

Definitions

- For the purposes of this section, “Adverse Benefit Determination” means a decision by Molina to deny, reduce or terminate a requested health care service or payment in whole or in part, including all of the following:
    - A determination that the health care service does not meet Molina’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
    - A determination that a health care service is not a Covered Service;
    - The imposition of an exclusion source of injury, network, or any other limitation on benefits that would otherwise be covered.

- Not to issue individual health insurance coverage to an applicant, including initial eligibility determinations;
- To rescind coverage on a health benefit plan.

“Final Adverse Benefit Determination” means an Adverse Benefit Determination that is upheld after the internal appeal process. If the period allowed for the internal appeal elapses without a determination by Molina, then the internal appeal will be deemed a Final Adverse Benefit Determination.

“Urgent Care Service” means a medical service where the application of non-Urgent Care Service time frames could seriously jeopardize:

- A Member’s life or health or Member’s unborn child; or
- In the opinion of the treating physician, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Appointing a Representative

If a Member would like someone to act on his/her behalf regarding a claim or an appeal of an Adverse Benefit Determination the Member may appoint an authorized representative. Members should send the representative's name, address, and telephone contact information to:

Appeals and Grievances Department	
Address:	Molina Healthcare of Ohio, Inc. Appeals and Grievance Department P.O. Box 349020 Columbus, Ohio 43234-9020
Telephone:	(888) 296-7677, Monday – Friday 8:00 am – 8:00 pm EST Saturday 8:00 am – 6:00 pm EST
TTY:	(800) 750-0750 or 711
Fax:	(866) 713-1891

Members must pay the cost of anyone they hire to represent them.

Internal Appeals

- Members must appeal an Adverse Benefit Determination within 180 days after receiving written notice of the denial (or partial denial). Members may appeal an Adverse Benefit Determination by means of written notice to Molina Healthcare, in person, orally, or by mail. The request should include:
    - The date of request
    - The date of the service denied
    - Member's name
    - Member identification number, claim number, and provider name as shown on the explanation of health care benefits, which the Member will automatically receive when the claim is processed

Members should keep a copy of the request for their records because no part of it can be returned.

Members may request an expedited internal appeal of an Adverse Benefit Determination involving an Urgent Care Service orally or in writing. In such cases, all necessary information will be transmitted between Molina and the Member by telephone, fax, or other available similarly expeditious method, to the extent permitted by applicable law.

Members may also request an expedited external review of an Adverse Benefit Determination involving an Urgent Care Service at the same time as a request is made for an expedited internal appeal of an Adverse Benefit Determination if the treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the

Member's life or health, or would jeopardize his/her ability to regain maximum function, if treated after the time frame of an expedited internal appeal (*i.e.*,72 hours).

Members may not file a request for expedited external review unless they also file an expedited internal appeal. Determination of appeals of Adverse Benefit Determinations will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial Adverse Benefit Determination or a subordinate of that person.

The determination will take into account all comments, documents, records, and other information submitted by the Member relating to the claim.

On appeal, the Member may review relevant documents and may submit issues and comments in writing. The Member may also, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of Molina in connection with the Adverse Benefit Determination being appealed, as permitted under applicable law.

If the Adverse Benefit Determination is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is Experimental or Investigational, or not Medically Necessary, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

If new or additional evidence is relied upon or if new or additional rationale is used during the internal appeal process, we will provide to the Member, free of charge, the evidence or rationale as soon as possible and in advance of the appeals decision in order to provide a reasonable opportunity to respond.

Time Periods for Decisions on Appeals

Appeals of Adverse Benefit Determinations will be decided and notice of the decision provided as follows:

TIME FRAME FOR RESPONDING TO APPEAL	
REQUEST TYPES	**TIME FRAME FOR DECISION**
URGENT CARE SERVICE DECISIONS	WITHIN 72 HOURS
PRE-SERVICE DECISIONS	WITHIN 30 CALENDAR DAYS
POST-SERVICES DECISIONS	WITHIN 60 CALENDAR DAYS

Appeals Denial Notices

Notice of a Final Adverse Benefit Determination (including a partial denial) will be provided by mail, by fax or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the Final Adverse Benefit Determination;
- Reference to the specific plan provision upon which the determination is based;
- If any internal Molina rule, protocol or similar criterion was relied upon to deny the claim, a copy of the rule, protocol or similar criterion will be provided to the Member, free of charge;
- A statement of the Member's right to external review, a description of the external review process, and the forms for submitting an external review request, including release forms authorizing Molina to disclose protected health information pertinent to the external Review; and
- If a Final Adverse Benefit Determination is based on Medical Necessity, Experimental or Investigational treatment or similar exclusion or limitation, the notice will provide an explanation of the scientific or clinical basis for the determination, free of charge. The explanation will apply the terms of this Agreement to the Member's medical circumstances. In addition to the information provided in the notice, Members have the right to request the diagnosis and treatment codes and descriptions upon which the determination is based. For assistance with appeals, complaints or the external review process Members may write or call:

Ohio Department of Insurance Consumer Affairs	
Address:	Ohio Department of Insurance ATTN: Consumer Affairs 50 W Town Street Suite 300 Columbus, OH 43215-1067
Consumer Affairs:	https://secured.insurance.ohio.gov/ConsumerServ/ConServComments.asp
Consumer Complaints:	http://Insurance.ohio.gov/Consumer/OCS/Pages/ConsComp;.aspx
Phone:	(614) 644-2673
Phone:	(800) 686-1526
TDD:	(614) 644-3745
Fax:	(614) 644-3744

External Review

Understanding the External Review Process

After a Final Adverse Benefit Determination is made, the Member may request an external review if he/she believes that a health care service has been improperly denied, modified, or delayed on the grounds that the health care service is not Medically Necessary.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) for Final Adverse Benefit Determinations involving Medical Necessity or medical judgment or by the Ohio Department of Insurance if the Final Adverse Benefit Determination involves a determination that the medical service is not covered by this Agreement. Molina will not choose or influence the IRO's reviewers.

There are three types of IRO reviews involving Medical Necessity or medical judgment:

- Standard external review;
- Expedited external review; and
- External review of Experimental or Investigational treatment

Standard External Review

A standard external review is normally completed within 30 days and applies to Adverse Benefit Determinations involving medical judgment.

Expedited External Review

An expedited review for urgent medical situations, including reviews of Experimental or Investigational treatment involving an urgent medical situation are normally completed within 72 hours and can be requested if any of the following applies:

- The treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the Member's life or health or would jeopardize his/her ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal or a standard external review.
- The Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the Member received emergency services, but have not yet been discharged from a facility.
- An expedited internal appeal is in process for an Adverse Benefit Determination of Experimental or Investigational treatment and the treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

External Review of Experimental and Investigational Treatment

Requests for standard or expedited external reviews that involve Adverse Benefit Determinations that a treatment is Experimental or Investigational may proceed if the treating physician certifies one of the following:

- Standard health care services have not been effective in improving the Member's condition;
- Standard health care services are not medically appropriate for the Member, or

- No available standard health care service covered by Molina is more beneficial than the requested health care service.

Request for External Review in General

Members must request an external review within 180 days of the date of the notice of final Adverse Benefit Determination issued by Molina Healthcare.

- All requests must be in writing, except for a request for an expedited external review.
- Expedited external reviews may be requested electronically or orally.

If the request is complete Molina will initiate the external review and notify the Member in writing that the request is complete and eligible for external review. The notice will:

- Include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information.
- Inform the Member that, within 10 business days after receipt of the notice, the Member may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in review.

Molina Healthcare will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete Molina Healthcare will inform the Member in writing and specify what information is needed to make the request complete.

If it is determined that the Adverse Benefit Determination is not eligible for external review, Molina Healthcare will notify the Member in writing and provide them with the reason for the denial and inform them that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Molina Healthcare and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of Molina Healthcare and all applicable provisions of the law. Molina Healthcare will pay the costs of the external review.

IRO Assignment

The Ohio Department of Insurance maintains a secure web-based system that is used to manage and monitor the external review process. When Molina Healthcare initiates an external review by an IRO in this system, the Ohio Department of Insurance system randomly assigns the review to an Ohio-accredited IRO that is qualified to conduct the review based on the type of health care service. Molina and the IRO are automatically notified of the assignment.

IRO Review and Decision

The IRO must forward, upon receipt, any additional information it receives from the Member to Molina Healthcare. At any time Molina Healthcare may reconsider its Adverse Benefit

Determination and provide coverage for the health care service. Reconsideration will not delay or terminate the external review. If Molina reverses the Adverse Benefit Determination, Molina Healthcare will notify the Member, the assigned IRO and the Ohio Department of Insurance within one day of the decision. Upon receipt of the notice of reversal by Molina Healthcare, the IRO will terminate the review.

In addition to all documents and information considered by Molina Healthcare in making the Adverse Benefit Determination, the IRO must consider things such as;

- The medical records;
- The attending health care professional's recommendation;
- Consulting reports from appropriate health care professionals;
- The terms of coverage under this Agreement; and
- The most appropriate practice guidelines.

The IRO will provide a written notice of its decision within 30 days of receipt by Molina of a request for a standard review or within 72 hours of receipt by Molina of a request for an expedited review. This notice will be sent to the Member, Molina Healthcare and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review;
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review;
- The dates over which the external review was conducted;
- The date on which the independent review organization's decision was made;
- The rationale for its decision; and
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision

Binding Nature of External Review Decision

An external review decision is binding on Molina except to the extent Molina Healthcare has other remedies available under state law. The decision is also binding on the Member except to the extent that they have other remedies available under applicable State or Federal law. They may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to Molina Healthcare.

Department of Insurance External review

A request for an external review of a Final Adverse Benefit Determination by the Ohio Department of Insurance may be requested if the Member believes that a health care service has been improperly denied, modified, or delayed on the grounds that the health care service is not covered under this Agreement or they are denied an external review of an Adverse Benefit Determination or Final Adverse Benefit Determination. The Member may contact the Ohio Department of Insurance:

Ohio Department of Insurance External Review Unit	
Address:	Ohio Department of Insurance ATTN: External Review Unit 50 West Town St. Suite 300 Columbus, OH 43215
Phone:	(614) 644-2673
Phone:	(800) 686-1526
TDD:	(614) 644-3745
Fax:	(614) 644-3744

Provider Claims Dispute

Provider Claim Disputes

Requests to dispute the processing, payment or nonpayment of a Claim by MHO shall be classified as a Provider Claim Dispute and shall be submitted via the following methods:

- Submit the request for Provider Claim Dispute via the Molina Provider Web Portal.
- Fax a completed Claims Reconsideration Request Form with any supporting documentation to (800) 449-3406.

Reporting

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

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

Record Retention

MHO will maintain all grievance and related appeal documentation on file for a minimum of ten (10) years. In addition to the information documented electronically via Call Tracking in QNXT or maintained in other electronic files, MHO will retain copies of any written documentation submitted by the Provider pertaining to the grievance/appeal process. Provider shall maintain

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

Section 12. Credentialing and Recredentialing

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

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

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

Definitions

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

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

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

Urgent Care Provider (UCP) - a Provider who is not a PCP and only provides urgent care services to Members. 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.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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. The Provider must sign and date the application	▪ 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 attachments are	All Provider types	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
attesting their application is complete and correct within one-hundred-eighty (180) calendar days of the credentialing decision. **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.** If Molina or the Credentialing Committee requests any additional information or clarification, the Provider must supply that information in the period requested. 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 initiated and dated by the Provider. If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina does	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			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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.				
License, Certification or Registration Provider must hold an active, current valid license, certification or registration to practice in their specialty in every State in which they will provide care and/or render services for Molina Members. If a Provider has ever had his or her professional license/certification/registration in any State suspended or revoked or Provider has ever surrendered, voluntarily or involuntarily, his or her professional license/certification/registration in any State while under or to avoid investigation by the State or due to findings by the State resulting from the Provider's acts, omissions or conduct, Molina will verify all licenses, certifications and registrations in every State where the Provider has	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

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
practiced.				
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. 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	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 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.	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

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
network.				
Education & Training 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.	As outlined below under Education, Residency, Fellowship and Board Certification.	All Provider Types	Prior to credentialing decision	Initial & Recredentialing
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 education has specifically been verified. ▪ The American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master	All Provider types	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	File. This verification must indicate the education has specifically been verified. ▪ 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. ▪ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. ▪ 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. ▪ If a physician has completed education and training through the AMA's Fifth Pathway program, this must be verified through the AMA. ▪ Confirmation directly from the National Student Clearing House. This verification must include the name of			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	the accredited school, type of education and dates of attendance.			
Residency Training 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 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.	Residency 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 Residency 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. ▪ Association of schools of the health	Oral Surgeons, Physicians, Podiatrists	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	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, specialty of training, the date started, date completed and if the program was successfully completed.			
Fellowship Training If the Provider is not board certified in the specialty in which they practice and has not completed a residency program they must have completed a fellowship program from an accredited training program in the specialty in	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	Physicians	Prior to credentialing decision	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
which they are practicing. When a Provider has completed a Fellowship, Molina always completes either a verification of Board Certification or Verification of Residency in addition to the verification of Fellowship to meet the NCQA requirement of verification of highest level of 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.			
Board Certification Board certification in the specialty in which the Provider is practicing is preferred but not required. Initial applicants who are not board certified may be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Molina recognizes board	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).	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

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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 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.	▪ 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 www.aboms.org (as applicable). ▪ On-line directly from the American Board of Addiction Medicine website https://www.abam.net/find-a-doctor/ (as applicable).			
General Practitioner Providers who are not board certified and have not completed a training program from an	The last five years of work history in a PCP/General practice must be included on the application or	Physicians	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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	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.			
Advanced Practice Nurse Providers 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)	Board certification is verified through one of the following: ▪ 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	Nurse Providers	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	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.			
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 (NCPPA).	Board certification is primary source verified through the following: ▪ On-line directly from the National Commission on Certification of Physician Assistants (NCPPA) website https://www.nccpa.net/.	Physician Assistants	One-hundred-eighty (180) Calendar Days	Initial and Recredentialing
Providers Not Able To Practice Independently 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	▪ Confirm from Molina's systems that the Provider providing supervision and/or oversight has been credentialed and contracted.	Nurse Providers, Physician Assistants and other Providers not able to practice independently according to State law	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Work History 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	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	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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 Provider must clarify the gap in writing.	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.			
Malpractice History 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.	▪ National Provider Data Bank (NPDB) report	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
State Sanctions, Restrictions on licensure or limitations on scope of practice Provider must disclose a	▪ Provider must answer the related questions on the credentialing application.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Provider must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Molina will also verify all licenses, certifications and registrations in every State where the Provider has practiced. At the time of initial application, the Provider must not have any pending or open investigations from any State or governmental professional disciplinary body.[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.	▪ 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.			
Medicare, Medicaid and other Sanctions	▪ The HHS Inspector General, Office of	All Providers	One-hundred-	Initial & Recredentialing

[3] 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.

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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. 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. Provider must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider.	Inspector General (OIG) is queried for every Provider. ▪ 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. ▪ The System for Award Management (SAM) system is queried for every Provider. ▪ The NPDB is queried for every Provider.		eighty (180) Calendar Days	
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	All Provider types	Must be in effect at the time of decision and verified within One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
The required limits are as follows: **Physician (MD,DO) Nurse Provider, Certified Nurse Midwife, Oral Surgeon, Physician Assistant, Podiatrist =** $1,000,000/$3,000,000 **All non-physician Behavioral Health Providers, Naturopaths, Optometrists =** $1,000,000/$1,000,000 **Acupuncture, Chiropractor, Massage Therapy, Occupational Therapy, Physical Therapy, Speech Language Pathology =** $200,000/$600,000	▪ Either the specific Provider name or the name of the group in which the Provider works ▪ Certificate must be legible Current Provider application attesting to current insurance coverage. The application must include 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 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			

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	liability or medical malpractice insurance ▪ Dates of coverage (must be currently in effect) ▪ Amounts of coverage			
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 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.	▪ 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. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
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 "drug" 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.	▪ 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	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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.	compliant in the program or has successfully completed the program. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision			
Criminal Convictions Provider must disclose if they have ever had any criminal convictions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Provider. Provider must not have been convicted of a felony or pled guilty to a felony for a health care related crime including but not limited to health care fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.	▪ 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. ▪ If there are any yes answers to these questions, and the crime is related to health care, a national criminal history check will be run on the Provider. ▪ The attestation must be signed and dated within one-hundred-eighty (180) calendar days of credentialing decision	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
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	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
	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.			
Hospital Privileges Providers must list all current hospital privileges on their credentialing application. If the Provider has current privileges, they must be in good standing. Providers may choose not to have clinical hospital privileges if they do not manage care in the inpatient setting.	The Provider's hospital privileges are verified by their attestation on the credentialing application stating the Provider has current hospital admitting privileges.	Physicians and Podiatrists	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
Medicare Opt Out 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.	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.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
NPI Provider must have a National Provider Identifier (NPI) issued by the Centers for Medicare and Medicaid Services (CMS).	▪ On-line directly with the National Plan & Provider Enumeration System (NPPES) database.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing
SSA Death Master File Providers must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration	▪ On-line directly with the Social Security Administration Death Master File database.	All Providers	One-hundred-eighty (180) Calendar Days	Initial & Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
Death Master File. 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 the credentialing application was correct. 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.				
Review of Performance Indicators 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.	Written documentation from the Molina Quality Department and other departments as applicable will be included in all recredentialing files.	All Providers	One-hundred-eighty (180) Calendar Days	Recredentialing
Denials 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.	▪ Confirmation from Molina's systems that the Provider has not been denied by the Molina Credentialing Committee in the past 1-year.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Terminations	▪ Confirm from	All Providers	One-hundred-	Initial

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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.	Molina's systems that the Provider has not been terminated by the Molina Credentialing Committee or terminated from the Molina network for cause in the past 5-years.		eighty (180) Calendar Days	Credentialing
Administrative denials and terminations Providers denied or terminated administratively as described throughout this policy are eligible to reapply for participation anytime as long as the Provider meets all criteria for participation.	▪ 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.	All Providers	One-hundred-eighty (180) Calendar Days	Initial Credentialing
Employees of Providers denied, terminated, under investigation or in the Fair Hearing Process 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	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.	All Providers	Not applicable	Initial and Recredentialing

CRITERIA	VERIFICATION SOURCE	APPLICABLE PROVIDER TYPE	TIME LIMIT	WHEN REQUIRED
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 least five percent (5%) financial interest in the company, through shares or other means.				

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 recredential the Provider upon his or her return. Molina will document the reason for the delay in the Provider’s file. At a minimum, Molina will verify that a Provider who returns has a valid license to practice before he or she can resume

seeing Patients. Within sixty (60) calendar days of notice, when the Provider resumes practice, Molina will complete the recredentialing cycle. If either party terminates their contract and there was a break in service for more than thirty (30) calendar days, Molina will initially credential the Provider before the Provider rejoins the network.

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 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 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 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:

6. 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.

7. 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.

8. 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.

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

10. 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.

11. 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.

12. 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.

13. 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.

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

15. 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.

16. Provider has or has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.

17. 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.

18. Provider has not complied with Molina's quality assurance program.

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

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

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

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

23. 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.

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

25. 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.

B. Definitions

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

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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.

L. 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.

M. 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.

N. 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.

O. 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.

P. Postponements

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

Q. 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.

R. 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.

S. 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.

T. 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.

U. 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.

Section 13. Glossary of Terms

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

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

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

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

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

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

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

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

make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by two or more family members enrolled as Members under the EOC reaches the specified Annual Out-of-Pocket Maximum amount, Molina will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that the subscriber or other family members enrolled as Members under the EOC pay for services that are not Covered Services under the EOC will not count towards the family Annual Out-of-Pocket Maximum.

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

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

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

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

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

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

Please refer to the Molina Healthcare of Ohio Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amount. The Member's product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

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

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

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

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

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

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

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

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

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

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

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

Emergency or **Emergency Medical Condition:** The acute onset of a medical condition or psychiatric condition that has acute symptoms of sufficient severity (including severe pain), 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 result in:

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

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

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

Ambulatory patient care

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

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

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

FDA: the United States Food and Drug Administration.

Habilitative Services: health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

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

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

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

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

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

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

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

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

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

Primary Care Provider or **"PCP":**

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

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

Service Area: the geographic area in Ohio where Molina has been authorized by the CMS to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

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

Spouse: the Subscriber's legal husband or wife.

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

Subscriber: means either:

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

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